No. 83-1284

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

AMERICAN HOSPITAL ASSOCIATION,
Plaintiff-Petitioner,

v.

MARGARET M. HECKLER, *et al.*,
Defendants-Respondents,

and

ILLINOIS MIGRANT COUNCIL, *et al.*,
Intervening Defendants-Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether the Hill-Burton regulations promulgated in 1979, more than thirty years after the enactment and five years after the termination of the Hill-Burton program, exceeded the authority granted to the Secretary of Health, Education and Welfare (now Health and Human Services) by the Hill-Burton Act in 1946.

2. Whether the 1979 Hill-Burton regulations substantially modified and expanded existing agreements between the Federal Government and Hill-Burton assisted hospitals, contrary to the principles expressed by this Court in *Pennhurst State School and Hospital* v. *Halderman*, 451 U. S. 1 (1981).

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OPINIONS BELOW

The opinion of the court of appeals in *American Hospital Association v. Schweiker, et al., and Illinois Migrant Council, et al.* (App. B, *infra*, 1b-33b), is reported at 721 F.2d 170 (7th Cir. 1983). The memorandum opinion of the district court, in *American Hospital Association v. Schweiker, et al.* (App. C, *infra*, 1c-15c), is reported at 529 F. Supp. 1283 (N.D. Ill. 1982). The opinion of the court of appeals denying preliminary relief in this matter, in *American Hospital Association v. Harris, et al., and Illinois Migrant Council, et al.* (App. D., *infra*, 1d-31d), is reported at 625 F.2d 1328 (7th Cir. 1980).

JURISDICTION

The judgment of the court of appeals was entered on November 1, 1983. The jurisdiction of this Court is invoked under 28 U.S.C. Sec. 1254(1) (1966).

STATUTE AND REGULATIONS INVOLVED

The Hill-Burton Act, Title VI of the Public Health Service Act, 42 U.S.C. Sec. 291 *et seq.* (1982), first enacted in 1946, has since its inception provided in relevant part:

> The Surgeon General, with the approval of the Federal Hospital Council and the Secretary of Health, Education and Welfare, shall by general regulations prescribe—
>
> * * *
>
> (e) that the State plan shall provide for adequate hospitals, and other facilities for which aid under this part is available, for all persons residing in the State, and adequate hospitals (and such other facilities) to furnish needed services for persons unable to pay therefor. Such regulations may also require that assurance shall be received by the State from the applicant that (1) the facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant;[1] and (2) there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

42 U.S.C. Sec. 291c(e). The regulations being challenged interpret the requirements of this section of the Hill-Burton Act. 42 C.F.R. Part 124, Subparts F and G (1982) (App. E, *infra*,

[1] The Hill-Burton Act was amended in 1964 to eliminate language allowing hospitals to make available "separate but equal" facilities (App. B, *infra*, 3b-4b.) This amendment is not at issue in this litigation. Otherwise, the language pertaining to the assurances in Section 291c(e) has remained unchanged since enactment in 1946.

1e-14e.) These regulations were promulgated by the Secretary of the U.S. Department of Health, Education and Welfare (now Health and Human Services) on May 18, 1979 and became effective no later than September 1, 1979.

STATEMENT

1. The American Hospital Association ("AHA") is the primary organization of hospitals in the United States. It is a not-for-profit membership corporation organized under the laws of the State of Illinois. The principal corporate objective of the AHA is "to promote the welfare of the public through its leadership and its assistance to members in the provision of better health services to all people." The membership of the AHA includes approximately 6,300 hospitals and other health care institutions, including 4,800 not-for-profit or public hospitals, as well as approximately 35,000 individuals.[2] Over seventy-five percent of these not-for-profit or public hospitals received assistance from the Hill-Burton program.

2. The Hill-Burton program provided assistance to not-for-profit and public hospitals in the form of grants or "low interest" loans[3] in return for assurances that assisted hospitals would provide a reasonable volume of services to the indigent. Only not-for-profit and public hospitals were eligible for these Hill-Burton grants or "low interest" loans. This petition concerns the validity of regulations promulgated in 1979 by the Secretary ("Secretary") of the U.S. Department of Health, Education and Welfare (now Health and Human Services) ("HHS" or "Department") interpreting the meaning of the two assurances provided for in the Hill-Burton Act. 42 U.S.C. Sec.

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[2] American Hospital Ass'n, *Hospital Statistics: 1982 Edition* (1982).

[3] The Hill-Burton Act provides a complex method for determining this interest rate. 42 U.S.C. Sec. 291j(c)(i). In 1976, the Hill-Burton loan rate was 5.6 percent.

291 *et seq.* (1982).[4] The regulations, codified at 42 C.F.R. Part 124, Subparts F and G, apply to all health care facilities which previously had received financial assistance under the Hill-Burton Act.

3. The Secretary promulgated proposed rules interpreting the two Hill-Burton assurances on October 25, 1978. The AHA reviewed these proposed rules and submitted comments to the Secretary on December 26, 1978. On May 18, 1979, the final Hill-Burton regulations were promulgated. The AHA filed suit on June 27, 1979, under the Administrative Procedure Act, 5 U.S.C. Sec. 701 *et seq.* (1977), against the Secretary and the Department to enjoin these regulations, and on August 27, 1979, moved for a temporary restraining order and a preliminary injunction. AHA contended that the 1979 Hill-Burton regulations exceeded the Secretary's statutory authority, violated hospitals' contractual rights and were unconstitutional. On August 31, 1979, the district court denied the motion for a temporary restraining order and granted several defendants leave to intervene in the suit. On October 1, 1979, the district court denied AHA's request for a preliminary injunction and on July 2, 1980, the U.S. Court of Appeals for the Seventh Circuit, in a 2-1 decision, affirmed the district court's denial of the preliminary injunction. (App. D, *infra.*)

4. On September 24, 1980, AHA filed a motion for summary judgment, and defendants subsequently filed cross-motions to the same effect. On January 8, 1982, Judge Nicholas

[4] The regulations at issue purported not to be promulgated under the statutory authority of the Hill-Burton Act (Title VI of the Public Health Service Act), but rather under Title XVI of the Public Health Service Act, enacted in 1975 and codified at 42 U.S.C. Sec. 300o *et seq.* (1982). The Secretary asserts that Title XVI is applicable even to hospitals assisted under Title VI. In this action, AHA disputes this assertion and limits its challenge to the applicability of the 1979 regulations to hospitals assisted under the Hill-Burton Act (Title VI of the Public Health Service Act).

J. Bua of the U.S. District Court for the Northern District of Illinois entered a memorandum opinion which denied AHA's motion for summary judgment and granted defendants' cross-motions for summary judgment. (App. C, *infra.*)

5. On February 24, 1982, AHA filed a notice of appeal from Judge Bua's order and sought to have the May 18, 1979, Hill-Burton regulations declared invalid. Oral argument occurred on October 27, 1982. The U.S. Court of Appeals for the Seventh Circuit affirmed the district court opinion on November 1, 1983. (App. B, *infra.*)[5]

REASONS FOR GRANTING THE PETITION

A. Importance of the Matter to Hospitals

The 1979 Hill-Burton regulations, promulgated more than thirty years after the inception of the Hill-Burton program and approximately five years after the last Congressional appropriations for hospital construction assistance under the original Hill-Burton Act, substantially increased the obligations of not-for-profit and public hospitals which had previously been assisted by the program. These retroactive changes in the Secretary's interpretation of the meaning of two Hill-Burton assurances were not authorized, either explicitly or implictly, by the Hill-Burton Act or by Congress. The U.S. Court of Appeals for the Seventh Circuit, in upholding the regulations, not only mis-

[5] The following is a list of defendants-appellees in this proceeding before the U.S. Court of Appeals for the Seventh Circuit: the Secretary of the U.S. Department of Health and Human Services (then Richard S. Schweiker); the U.S. Department of Health and Human Services; and, as intervening defendants-appellees, the Austin Welfare Rights Organization, Inc. (a Texas, not-for-profit corporation); Eldora Cain; Mary Gendron; the Illinois Migrant Council, Inc. (an Illinois, not-for-profit corporation); the Massachusetts Health Care Coalition; Celia Pena; and Linda Withrow.

construed the legislative history of the Act and the clear wording of the statute, but misinterpreted this Court's recent decisions regarding government attempts to change retroactively substantive requirements for federal grant recipients. By so doing, the circuit court acquiesced in the imposition of a substantial additional burden on assisted hospitals which will either contribute to their financial difficulties or be passed on to paying patients.[8]

This case is of critical importance to this nation's not-for-profit and public hospitals. Between 1947 and 1971, 2267 not-for-profit and 1398 public hospitals accepted construction assistance under the Hill-Burton program. Public Health Service, U.S. Dep't of Health, Education, and Welfare, *Facts About the Hill-Burton Program, July 1, 1947-June 30, 1971* at 4 (1972). All of these hospitals are now subject to the regulations promulgated in 1979, even though they could have had no information about the requirements of the 1979 regulations at the time they accepted Hill-Burton assistance.

In contrast to the regulations in effect at the time hospitals received assistance under the original Hill-Burton program, the 1979 Hill-Burton regulations require, *inter alia*, that:

- An assisted hospital provide a fixed quota of uncompensated care, regardless of the need for such care in the community or the financial impact of providing the care to the hospital;
- An assisted hospital participate in perpetuity in the Medicare and Medicaid programs; and
- An assisted hospital allow physicians treating Medicare or Medicaid patients to practice at the hospital or take affirmative steps to reorganize its medical staff to assure that Medicare and Medicaid patients are treated, regardless of the wishes of those patients, the adverse financial impact on the hospital, or its medical staff practices.

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[8] J. Meyer, Passing the Health Care Buck: Who Pays the Hidden Cost? (1983).

In essence, the 1979 regulations have altered the Hill-Burton program from a contractual federal assistance program for hospital construction into a program that imposes onerous administrative and financial requirements on assisted hospitals that were clearly not within the contemplation of Congress when it enacted the legislation.

B. The Decision of the Court of Appeals for the Seventh Circuit Is In Clear Conflict With the Statutory Language and Legislative History

The Hill-Burton Act created a program primarily to construct or modernize hospitals. In return for construction funds, hospitals agreed to several conditions, including the two assurances at issue here. The language of the statute and its legislative history clearly show that Congress did not intend requirements of the kind promulgated in the 1979 Hill-Burton regulations.

The first rule in ascertaining statutory intent is to read the words of the statute. *Chicago Transit Authority* v. *Adams*, 607 F.2d 1284 (7th Cir. 1979), *cert. denied*, 446 U.S. 946 (1980). The Hill-Burton Act, as amended in 1964, provides that the Surgeon General[7] may issue regulations requiring that the state agency must receive the applicant's assurances that

> (1) the facility or portion thereof to be constructed *will be made available* to all persons residing in the territorial area of the applicant; and (2) there *will be made available* in the facility or portion thereof to be constructed a reasonable volume of services to persons unable to pay therefor,

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[7] In 1966, the Office of the Surgeon General was abolished by Section 3 of Reorg. Plan No. 3 of 1966, 31 Fed. Reg. 8855 (1966), *reprinted* 80 Stat. 1610 (1966), and all functions thereof were transferred to the Secretary of Health, Education and Welfare. In 1979, the "Secretary of Health and Human Services" was substituted for "Secretary of Health, Education and Welfare" in the text pursuant to 20 U.S.C. Sec. 3508(b) (1983 Supp.).

but an exception shall be made if such a requirement is not feasible from a financial standpoint. (Emphasis provided.) 42 U.S.C. Sec. 291c(e).

The Act itself, therefore, clearly requires only that hospitals "make available" health care services to all residents and a "reasonable volume of services" to those unable to pay unless it is not financially feasible. Clearly, it does not mandate that hospitals provide a fixed quota of such services regardless of the financial impact on the hospital, as the 1979 regulations require.

A statute must be construed with reference to the circumstances existing at the time of its passage and in light of the conditions under which Congress acted at the time. *Moor* v. *County of Alameda*, 411 U.S. 693 (1973); *United States* v. *Wise*, 370 U.S. 405 (1962); *Ries* v. *Lynskey*, 452 F.2d 172 (7th Cir. 1971). The circumstances and conditions existing at the time of the enactment of the Hill-Burton Act reveal an overwhelming Congressional concern for the construction of adequate health care facilities and for additional legislation approaching some sort of national health insurance.[8] The legislative history also reveals that Congress was aware of the traditional practice of hospital charity care and chose to support the continued provision of such care by providing federal assistance to construct new facilities in which such care would be available.[9] Certainly none of the circumstances and conditions present during the consideration of the Act in 1946 could be said to support the complex regulatory scheme promulgated so many years later in blatant disregard of the economic consequences to hospitals.

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[8] *See Hearings on S. 191 Before the Senate Comm. on Education and Labor*, 79th Cong., 1st Sess. 10 (1945); at 31 (statement of Sen. Pepper that the program was a "first step"); at 63-65 (colloquy between Sens. Smith and Ellender characterizing the bill as limited to the provision of physicial facilities).

[9] *See generally* 91 Cong. Rec. 11711, 11795 (1945).

The opinion of the circuit court plainly distorted the legislative history of the original Hill-Burton Act. It cited in particular a March 12, 1945, colloquy among Senators Ellender, Pepper and Taft and Dr. Frederick Mott, a Department of Agriculture official. (App. B, *infra*, 10b-12b.) The court below correctly emphasized that providing improved access to health care services for the indigent was of concern to the Hill-Burton Act's supporters. The colloquy does not, however, support the circuit court's broader conclusion that the Act itself was intended to authorize ever-increasing quotas of uncompensated care from assisted hospitals, regardless of economic consequences. Rather it highlights the fact that the option of requiring hospitals to provide such a fixed amount of services to the indigent was discussed and specifically rejected by Congress.

The legislative history of the original Hill-Burton Act illuminates the overwhelming and controlling purpose of the Act: to assist communities in constructing adequate health care facilities. This is evident from the very introduction of the Act (S. 191), when Senator Hill summarized his intent in sponsoring the legislation:

> The first purpose [of S. 191] is to assist the States in making a careful State-wide survey of hospitals and health care facilities ... in order to determine where additional facilities are needed and to prepare a State-wide program for new construction so that all people of the State may have adequate health and hospital service....
>
> The second purpose ... would be to assist States, counties, cities and communities to provide for themselves modern hospitals and health centers....
>
> The third purpose ... is to assist and encourage the States to correlate and integrate their hospital and public-health services and to plan additional facilities when and where needed....

> No great increase in either [sic] public health, hospital, or medical services can be expected unless we have a much better distribution of modern hospital and health-center facilities. *Hearings on S. 191 Before the Senate Comm. on Education and Labor,* 79th Cong., 1st Sess. 8-9 (1945).

In addition, it is significant that other provisions of the bill are spelled out in substantially greater detail than the assurances at issue herein. For example, Congress drafted in considerable detail the allotment formula by which federal funds would be distributed to the states, the content of application forms, the method of project approval, and the method of payment for construction. Thus, the very brief and general language of the assurances, in contrast to the detailed provisions regarding the general administration of the program, has led one law review commentator to note that:

> Although use of Congress' failure to provide the same detail in these provisions as it did in others, as with any interpretation based on what a legislature has not done, is necessarily inconclusive, an obvious inference to be drawn from this contrast is that Congress did not intend that the obligations would be a major financial factor in the program. Other discussion in committee hearings shows that the Senators understood that the financing of medical services for the indigent was a complicated financial problem. Brown, *The Hill-Burton Act, 1946-1980: Asynchrony in the Delivery of Health Care to the Poor,* 39 Md. L. Rev. 316, 322 n.28 (1980).

In 1975, Congress enacted Title XVI of the Public Health Service Act to succeed the original Hill-Burton program.[10] 42 U.S.C. Sec. 300o *et seq.* (1982). The new act contained language requiring assurances almost identical to those of Title

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[10] With very few exceptions, particularly relative to the repair of public hospitals, Congress failed to appropriate funds to implement Title XVI.

VI, but its provisions were mandatory on the Secretary and were supported by investigatory and enforcement mechanisms. 42 U.S.C. Secs. 300s-1(b)(1)(K), 300s-6. The circuit court erroneously held that the inclusion of the new enforcement provisions provided additional authority to support the 1979 regulations and their application to facilities that had previously received funds under the original Hill-Burton Act (Title VI of the Public Health Service Act). (App. B, *infra*, 14b-15b.)

In enacting Title XVI, Congress was primarily concerned with the rudimentary state of compliance monitoring by the States with regard to the assurances. Testimony at the 1974 hearings preceding the enactment of Title XVI did not criticize compliance by individual hospitals, but rather the performance of government in monitoring compliance.[11] Thus, Congress did not direct that the obligations be expanded in substance. Certainly, if Congress had intended to establish different or more onerous obligations, it could have done so in precise language, as it indeed did in establishing the new enforcement procedures.

Consistent with the language of the statute and its legislative history, the regulations in effect prior to the 1979 regulations consistently permitted hospitals to "make care available" to the indigent of their communities by "opening their doors" to all who requested assistance.[12] In 1979, the Secre-

[11] The 1974 Senate Report, for example, focused on "... the disturbing information concerning the administration of the Hill-Burton program," and the "sorry performance by the Department and the state Hill-Burton agencies ..." and indicated that the provisions of Title XVI were "intended to strengthen efforts to enforce these assurances." S. Rep. No. 1285, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. Code Cong. & Ad. News 7842.

[12] Although the regulations in effect prior to 1979 did not require that hospitals record the amount of services they provided under the "open door" option, numerous affidavits presented at the district court

Footnote continued on following page.

tary, through the regulations at issue, eliminated this "open door" option for the first time and substituted a fixed quota of care which an assisted hospital must provide, regardless of any other circumstances. The circuit court stated, in defense of the Secretary's actions, that "[t]here is ample support in the record for the conclusion that the 'open door option' (under which an assisted facility would merely certify that it would not exclude persons from admission based on inability to pay) did not work." (App. B, *infra*, 16b-17b.) It cited the records of agency hearings in 1978 as evidence of this option's failure and concluded that the Secretary, when specifying quantitative compliance levels, "was not only acting within his statutory authority to define what constituted a 'reasonable volume of services' but was also responding to manifestations of Congressional discontent with past failure to monitor and enforce the statutory assurances." *Id.* at 17b.

Notwithstanding the circuit court's assertion, the Secretary has produced no evidence of hospitals' failure to comply with

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Footnote continued from preceding page.

demonstrate that, under the "open door" option, many hospitals kept detailed financial accounts of the costs of uncompensated care they provided. These records indicate that institutions incurred substantial uncompensated care costs and that many "never turned anyone away from receiving ... services because of inability to pay." *See, e.g.*, Affidavit of William R. Rundle, Wadsworth-Rittman Hospital, Wadsworth, OH (A-104-107).

Under the 1979 regulations, an assisted hospital is in violation of its assurances even if it demonstrates it has never turned anyone away as long as it does not furnish its fixed quota of care. 42 C.F.R. Sec. 124.503. The circuit court erroneously referred to this fixed quota as "presumptive" compliance. (App. B, *infra.*, 18b.) Unlike the standard of "presumptive" compliance contained in the 1972 Hill-Burton regulations, however, the fixed quota of the 1979 regulations is not a "presumptive" compliance standard, but is rather a compliance standard.

the Hill-Burton assurances.[13] In actuality, the arbitrary elimination of the "open door" option is not only inconsistent with the statutory language and legislative history but it capriciously penalizes hospitals for the inadequate performance of HHS and state Hill-Burton agencies in monitoring compliance with the uncompensated care obligation.

The Hill-Burton statute further provides that assisted hospitals need not make available a reasonable volume of services to the indigent "if such a requirement is not feasible from a financial viewpoint." 42 U.S.C. Sec. 291c(e). The 1979 regulations fail to give effect to this statutory language, pro-

[13] The Secretary's own figures fail to indicate that hospitals were not fulfilling their Hill-Burton obligations prior to issuance of the 1979 regulations. In response to an AHA Freedom of Information Act ("FOIA") request on November 22, 1978, the Secretary admitted that, since 1975, only 206 complaints had been received against Hill-Burton facilities, and that HEW had undertaken complete investigations regarding only 96 of those complaints. Furthermore, in response to another AHA FOIA request on December 5, 1978, HEW admitted that there were only 57 complaints filed against facilities with the various state agencies, without any indication of the portion that resulted in determinations of noncompliance. Of the 33 states reporting, 22 states — exactly two thirds — reported no Hill-Burton complaints received for an entire year. Therefore, the Secretary's and the court's conclusion that the 1979 regulations were necessary because hospitals were not fulfilling their Hill-Burton obligations is clearly erroneous. *See* Affidavit in the district court of Ellen A. Pryga, American Hospital Association (A-114-127).

Furthermore, the opinion of the circuit court cited only a law review comment to support its proposition that Hill-Burton hospitals "displayed a marked reluctance to give even the most token charitable care." (App. B, *infra*, 4b.) While this 1973 article examines several cases in which courts had determined that the charity care obligations of individual hospitals had not been met, its evidence of widespread abuse is referenced only in private letters to the law review. *See* Comment, *Provision of Free Medical Services By Hill-Burton Hospitals*, 8 Harv. C.R.-C.L. L.Rev. 351 (1973).

viding that financial infeasibility can be used only to defer, not to eliminate or to reduce the amount of the required obligation.

Mid-Louisiana Gas Co. v. *Federal Energy Regulatory Commission*, 664 F.2d 530 (5th Cir. 1981), provides:

> The [Secretary's] duty is to administer the law in light of the purposes for which it was passed. It is not an agency's prerogative to alter a statutory scheme even if its alteration is as good or better than the congressional one. *Id.* at 534.

The Secretary can point to no statutory language or legislative history to support the elimination of the financial infeasibility exception. The court below, specifically not deciding the question, only noted that the Hill-Burton Act does not necessarily mandate a total waiver of the uncompensated care obligation when a facility is unable to pay. (App. B, *infra*, 19b-21b.) The circuit court failed to accord due consideration to the 33 year consistent interpretation of the statute held by all parties, including the federal agency that promulgated the regulations at issue. The Secretary's action to alter this interpretation cannot be presumed so facilely to accord with his statutory obligations.

In addition, the 1979 regulations require hospitals receiving grants under federal programs completely unrelated to the Hill-Burton program to increase the base for calculating the amount of their uncompensated care obligation by the amount of such grants. 42 C.F.R. Sec. 124.502. Yet there is no statutory language whatsoever to support this regulation nor is there any evidence that such a requirement was remotely within the contemplation of Congress. In fact, most of these supplemental grant programs are administered by federal agencies other than HHS. *See, e.g.*, Public Works & Economic Development Act, 42 U.S.C. Sec. 3121 *et seq.* (1977); Local Public Works Capital Development & Investment Act of 1976, 42 U.S.C. Sec. 6701 *et seq.* (1983).

Furthermore, the 1979 regulations require all Hill-Burton hospitals to participate in perpetuity in the Medicare and Medicaid programs, regardless of any adverse financial con-

sequences to the hospital, 42 C.F.R. Sec. 124.603(c)(1)(ii), and in spite of the clear language of the statute requiring only a "reasonable volume of uncompensated care" and the Act's exception for financial infeasibility. The 1979 regulations do not even allow the hospital to be credited, in meeting its uncompensated care obligation, for the difference between the actual costs incurred in providing care to Medicare and Medicaid patients and those programs' payment rates.[14] 42 C.F.R. Sec. 124.509(b). Not only does this produce a substantial change in the Hill-Burton contractual obligations, it also creates an unlimited, perpetual uncompensated care program.[15]

The Medicare and Medicaid programs are designed to be voluntary programs wherein participating hospitals are given notice regarding statutory reimbursement and voluntarily agree to participate and to accept the government's payment, even if it is less than actual costs. However, as a result of the 1979 regulations promulgated no less than five years after the termination of the Hill-Burton program, the acceptance of Hill-

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[14] The circuit court argued that all hospitals face the problem of Medicare and Medicaid shortfalls. (App. B, *infra*, 18b-19b.) Nevertheless, other hospitals are free not to participate in those programs, but hospitals that accepted Hill-Burton assistance are required by the 1979 regulations to participate in perpetuity. Many Hill-Burton hospitals received construction assistance prior to the enactment of the Medicare and Medicaid programs in 1966.

[15] On average, in 1980, a community hospital received 8.5 percent of its operating revenue from Medicaid and approximately 36.0 percent from Medicare. American Hospital Ass'n., *Policy Brief No. 47: Hospital Involvement with Medicare and Medicaid: A Statistical Profile* 5 (June 15, 1983). The difference between actual costs and Medicare and Medicaid payments is significant. For example, Allegheny General Hospital, Pittsburgh, PA, stated in an affidavit before the district court that the regulations would disallow $1.3 million for FY 1980 (A-107-113); Episcopal Hospital, Philadelphia, PA, stated the regulations disallowed $432,469 in 1978 (A-137-141) Even the circuit court recognized that the Medicare and Medicaid shortfall could, by itself, be greater than the quota required by the 1979 regulations. (App. B, *infra*, 19b.)

Burton funds is used to mandate retroactively that a facility participate in these otherwise voluntary programs and that it provide services without limit.

The Medicare and Medicaid programs do not now pay hospitals the actual costs of providing care, if they ever did.[16] Indeed, neither program currently pays hospitals under a cost-based methodology.[17] Thus, by requiring hospitals to participate in perpetuity in these programs, the government subjects them to certain financial losses which cannot be counted as partial fulfillment of the institution's uncompensated care obligation, even to the extent that the losses are suffered as a result of providing uncompensated care to indigents.

The circuit court accepted, without discussion and in a footnote, that the hospital's community service obligation is perpetual.[18] (App. B, *infra*, 20b.) Yet Congress clearly intended to impose a durational limitation on both Hill-Burton assurances, and even the Secretary has recognized the 20 year limitation in the 1979 regulations with regard to the uncompensated care assurance, but not with the community service assurance. 42 C.F.R. Sec. 124.501(b)(1)(i). Indeed, the community service and the uncompensated care obligations are contained in the same section of the statute and both obligations have been understood by hospitals, the states and the federal government itself to be covered by a 20 year limitation.

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[16] The Medicare and Medicaid programs fail to pay health care providers for the actual costs of services they provide to beneficiaries of those programs. Experts estimate that the extent of this shortfall ranged from $2-3 billion in 1979 and $6-7 billion in 1983. J. Meyer, *supra* note 6, at 9.

[17] *See* 42 U.S.C. Sec. 1396a(13)(A) (1983 Supp.) (Medicaid); Social Security Act Amendments of 1983, Pub. L. No. 98-21 (March 24, 1983) (Medicare).

[18] The 1979 Hill-Burton regulations use this requirement to mandate an assisted hospital's participation in the Medicare and Medicaid programs.

In addition, this 20 year durational limit is consistent with 42 U.S.C. Sec. 291i, which provides for recovery of a portion of the assistance if the hospital discontinues operations or changes its not-for-profit or public status. The circuit court, in a footnote, discounted this reasoning, holding that Section 291i "has little relevance to the duration of the Hill-Burton facilities' assurances." (App. B, *infra*, 20b.) The court's holding is illogical. Obviously, if the government's ability to recover Hill-Burton funds as a result of the hospital's sale or discontinuation of operations has a 20 year durational limit, then the institution's community service and uncompensated care obligations under the same statute must also be limited to the same time period.

The 1979 Hill-Burton regulations clearly intrude into daily hospital operations in controvention of the Hill-Burton Act. The Hill-Burton Act provides:

> Except as otherwise *specifically* provided, nothing in this subchapter shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance or operation of any facility with respect to which any funds have been or may be expended under this subchapter. (Emphasis provided.) 42 U.S.C. Sec. 291m.

The 1979 regulations attempt to control both the administrative operation of hospitals and the conduct of physicians by mandating (1) that if a hospital has a policy of admitting only those patients whose physicians have staff privileges, the hospital must take affirmative measures to accommodate patients who do not use or have such physicians; (2) that if physicians in any of the hospital's departments do not accept Medicaid patients, the hospital must establish a clinic or hire physicians who will treat Medicaid patients; and (3) that hospitals are effectively forbidden to require deposits as a condition of admission even for those who are able to pay. 42 C.F.R. Sec. 124.603(d).

The circuit court incorrectly interpreted the plain meaning of the Act: unless the Act specifically allows the federal government to intrude into the operation of a hospital, any regulations which have such an effect are invalid.[19] *See Euresti* v. *Stenner*, 458 F.2d 1115, 1119 (10th Cir. 1972). To conclude that Section 291c(e), which states that regulations may require the availability of "uncompensated care" and "community service," specifically provides authority for the disputed regulations disregards the word "specifically" in Section 291m and robs the provision of any meaning whatsoever. Under this reasoning, any regulation promulgated pursuant to the uncompensated care or community service assurances would be permissible, regardless of its impact on the operations of a hospital.

C. The 1979 Hill-Burton Regulations Are Contrary to the Principles Expressed By This Court in *Pennhurst State School and Hospital* v. *Halderman*

The Secretary of HHS is clearly charged with the responsibility to monitor and enforce the Hill-Burton assurances. In the 1979 Hill-Burton regulations, however, the Secretary has not merely attempted to enhance the enforcement, monitoring and reporting aspects of the Hill-Burton program, but has also increased significantly the obligations imposed on institutions that had previously received Hill-Burton assistance. Although the Hill-Burton Act's statutory assurance provisions have continued unchanged, the obligations, burdens and conditions

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[19] The legislative history supports this interpretation. The House Committee Report provides:

> "The concluding section of the new Title VI makes it clear that, *except in the matters specifically dealt with elsewhere in the Title*, the proposed new Title does not confer on any Federal officer or employee any supervisory authority over the administration, personnel, maintenance, or operation of any hospital receiving Federal aid under the Title." (Emphasis added.) H.R. Rep. No. 2519, 79th Cong., 2d Sess. 113 (1946).

imposed upon assisted hospitals have been substantially increased and expanded by the 1979 regulations. Thus, this petition challenges the government's unilateral, retroactive imposition of additional and unforeseen substantive conditions on those hospitals that received Hill-Burton funds many years before the 1979 regulations were promulgated.

The court below misread *Pennhurst State School and Hospital* v. *Halderman,* 451 U.S. 1 (1981), and ignored the principles stated in that case. *Pennhurst* unequivocally provides (1) that federal grant programs are contractual in nature; (2) that if the federal government intends to impose a condition upon the grant of federal monies, it must do so unambiguously; and (3) that Congress cannot impose postacceptance or retroactive substantive conditions upon grant recipients.

Analyzing Congress' power to legislate pursuant to the spending clause, this Court stated in *Pennhurst* that

> Unlike legislation enacted under Sec. 5 [of the Fourteenth Amendment] however, legislation enacted pursuant to the Spending Power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. 451 U.S. at 17.

The circuit court refused even to accept the proposition that a grant of funds under the Hill-Burton program created a contractual relationship between hospitals and the federal government,[20] even though the Hill-Burton program was enacted pursuant to the spending power of Congress. It preferred rather to treat the Hill-Burton program as a grant-in-aid scheme whereby the "government acts by inducing a state or private

[20] Numerous other courts, however, have recognized that the Hill-Burton program creates a contractual relationship between an assisted hospital and the Federal Government. *See, e.g., American Hospital Ass'n* v. *Harris* (App. D, *infra,* 7d-31d) (Pell, J., concurring in part and dissenting in part); *Euresti* v. *Stenner,* 458 F.2d 1115, 1118-19; *Lugo* v. *Simon,* 426 F. Supp. 28, 31 (N.D. Ohio 1976).

party to cooperate with the federal policy by conditioning receipt of federal aid upon compliance by the recipient with federal statutory and administrative directives."[21] (App. B, *infra*, 23b.) The circuit court further implied that because the arrangement was not the result of a negotiated agreement between the government and assisted hospitals, contractual principles were inapplicable.[22]

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[21] In support of this proposition, the court below cites *Fullilove* v. *Klutznick*, 448 U.S. 448, 474 (1980), a case dealing with the minority business enterprise provision of the Public Works Employment Act of 1977, 42 U.S.C. Sec. 6701 *et seq.* (1983). That Act requires that, absent an administrative waiver, at least 10 percent of federal funds granted for local public work projects must be used by the local grantee to procure services or supplies from businesses owned by minority group members. Petitioners, several associations of construction contractors and subcontractors and a construction firm, alleged economic injury due to the enforcement of the Act and that the Act, on its face, violated the Fourteenth Amendment's equal protection clause and the Fifth Amendment's due process clause. The district court upheld the validity of the Act, and the Court of Appeals and this Court affirmed.

The situation in *Fullilove* differs greatly from the instant case. In *Fullilove*, there were no unexpected additional requirements imposed upon recipients years after the actual grant of funds; the Public Works Employment Act and regulations issued pursuant to it clearly spelled out the requirements that a recipient would have to meet before any funds were promised or received. In addition, the petitioners in *Fullilove* challenged the Act itself on constitutional grounds. In the case at bar, AHA does not challenge the constitutionality of the Hill-Burton Act, only those regulations promulgated under it in 1979 which imposed onerous obligations on grant recipients years after the money was actually received.

[22] The assurances of the Act discussed by this Court in *Pennhurst* and in most federal grant programs are not negotiated at arms length. It is unclear why the court below believed this factor to be significant. The key point under *Pennhurst* is that a grantee must know what the conditions are before acceptance of funds.

The similarity is evident between the Developmentally Disabled Assistance and Bill of Rights Act of 1975 42 U.S.C. Sec. 6000 *et seq.* (1983), discussed by this Court in *Pennhurst* and the Hill-Burton Act at issue herein. This Court in *Pennhurst* held: (1) that the Act in *Pennhurst* was a federal-state grant program enacted pursuant to the spending power as is the Hill-Burton Act; (2) that the Act in *Pennhurst* was voluntary because the States were given a choice of complying with the conditions set forth in the Act or foregoing the benefits of federal funding. Likewise, the Hill-Burton program is voluntary since hospitals initially were also given a choice to participate; and (3) that each state under the Act discussed in *Pennhurst* was required to give various assurances, as must Hill-Burton assisted hospitals. In fact, if one were to substitute the word "hospitals" for "state" in the Act discussed in *Pennhurst,* much of the *Pennhurst* discussion would directly apply to the case at bar.

The *Pennhurst* Court, after finding that grants of federal funds under the spending power are contractual in nature, further held that

> The legitimacy of Congress' power to legislate under the Spending Power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' (Citations omitted.) There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously. 451 U.S. at 17.

In *Lieberman v. University of Chicago,* 660 F.2d 1185, 1187 (7th Cir. 1981), the majority opinion interpreted *Pennhurst* to stand for the proposition that "conditions to be imposed by Congress must be stated in unambiguous terms." In his dissent on the merits, Judge Swygert stated that "the majority accurately characterizes the Court's reasoning in *Pennhurst,*" *Id.* at 1198, and emphasized that when Congress

imposes substantive conditions on a recipient of funding, those conditions "must be explicitly stated by Congress." *Id.* at 1191. Yet the circuit court did not mention, let alone distinguish its own prior decision in *Lieberman.*

Hill-Burton grants and loans contained only two conditions in the nature of assurances applicable to the case at bar: (1) that the hospital must make available a reasonable volume of uncompensated care; and (2) that the hospital must make services available to everyone in the community. A hospital could not be expected to know that it would be subject to the rigid requirements and quotas of the 1979 regulations when it originally accepted funds under the Hill-Burton Act and gave the two assurances. To use the language of this Court in *Pennhurst,* 451 U.S. at 25, it "strains credulity" to argue that an assisted hospital should have foreseen its expanded obligations under the 1979 regulations, particularly when those regulations completely altered the meaning of the obligations held by the federal government, the states and participating hospitals for over 30 years. Therefore, since the terms and conditions imposed by the 1979 Hill-Burton regulations were not set forth clearly and unambiguously by HHS, let alone by Congress, prior to the time that hospitals received Hill-Burton assistance, the regulations are invalid under *Pennhurst.*

The court below misread the *Pennhurst* decision. It determined that *Pennhurst* was "quite different from the case at hand" because it addressed the question of whether a federal statute created enforceable substantive rights, not whether an agency's interpretation of obligations under a statute for which it is responsible was correct. (App. B, *infra,* 24b-25b.) The circuit court was apparently intending to draw a distinction between subsequent conditions imposed by Congress and those imposed by administrative agencies. AHA maintains that a correct reading of *Pennhurst* renders this attempted distinction invalid.

In support of its opinion that the contract analogy has only limited application to the Hill-Burton regulations being chal-

lenged, and that therefore *Pennhurst's* contract principles should not apply, the circuit court cited several cases which it claimed supports the "government's right, when undertaking a regulatory scheme, to alter the expectations and obligations of private parties." *Id.* at 24b. A closer examination of these cases indicates that their application to the case at bar is limited.

The court below first cited *FHA* v. *The Darlington, Inc.*, 358 U.S. 84 (1958). The *Darlington* case involved a housing developer who constructed rental apartments with federal funds, some of which were then rented to transients, a practice the FHA consistently maintained was never authorized. Congress, five years after the developer had obtained FHA mortgage insurance, passed a new section to the Act in question which stated that it had never been the intent of Congress that rentals be made to transients. *See* 12 U.S.C. Sec. 1743 (1982).

FHA v. *The Darlington, Inc.*, does not stand for the proposition that retroactive amendments to substantive laws are constitutionally permissible where there is a contractual relationship. First, the *Darlington* Court clearly held that the contractual rights at issue were not substantial. *Id.* at 91. As has been illustrated, this is not the case here. Second, the Act in question in *Darlington* specifically allowed the agency to regulate or restrict rents or sales, charges, capital structure, rate of return, and method of operation. *Id.* at 85. The Hill-Burton regulatory scheme clearly does not allow HHS as broad a mandate. The most important distinction, however, between *Darlington* and the case at bar is that one could "buy out" of the FHA mortgages discussed in *Darlington*, while the hospital's obligation under the Hill-Burton program is perpetual and cannot be excused, even if the hospital is willing and able to return its Hill-Burton assistance. Indeed, having once accepted Hill-Burton funds, a hospital cannot end its obligations under the 1979 regulations even if it offers to pay back the Hill-Burton money it had received with interest and a penalty.[23] This

[23] There is no provision in the Hill-Burton Act or regulations that

Footnote continued on following page.

presents an untenable situation for institutions, precisely because it was impossible for them to have anticipated the changed and increased Hill-Burton obligations of 1979 regulations.

The court below also relied upon *Thorpe* v. *Housing Authority*, 393 U.S. 268 (1968), and *Usery* v. *Turner Elkhorn Mining Co.*, 428 U.S. 1 (1976), to support its position. (App. B, *infra*, 24b.) *Thorpe* involved an attempt by a federally-assisted housing project to evict a tenant. During the course of judicial proceedings, the federal government imposed a new requirement that notice be provided before evicting tenants. As this Court stated,

> The *respective obligations* of both HUD and the Authority under the annual contributions contract *remain unchanged.* Each provision of that contract is as enforceable now as it was prior to the issuance of the circular. 393 U.S. at 279. (Emphasis added.)

The *Thorpe* Court further found that "requiring the Authority to apply the circular before evicting petitioner not only does not infringe upon any of its rights, but also does not even constitute an imposition." *Id.* at 283. The same cannot be said of the significant changes in hospitals' legal obligations wrought by the 1979 Hill-Burton regulations.

Turner Elkhorn did not involve a contractual relationship between the federal government and a private party, but rather dealt with the constitutionality of the Black Lung Benefits Act of 1972, 30 U.S.C. Sec 901 *et seq.* (1970 and Supp IV). The Act at issue was passed pursuant to Congress' commerce and police powers, and therefore did not create a contractual

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would allow an assisted hospital to terminate its obligations under the Act and to pay back the assistance it received under the program. The Act's only payback provision relates to the hospital's partial repayment of Hill-Burton assistance when it discontinues operations or changes ownership status. 42 U.S.C. Sec. 291i.

relationship under the spending power clause as occurs under the Hill-Burton Act. Thus, these cases, heavily relied upon by the court below, are inapposite.

The circuit court held that even if it accepted the proposition that the Hill-Burton Act created a contractual relationship between the assisted facility and the federal government, and the principles enunciated in *Pennhurst* were applied, it would still uphold the 1979 regulations. (App. B, *infra,* 25b-26b.) It found that the two Hill-Burton obligations were unambiguous and that "applicants were required to comply with whatever regulations were issued pursuant to section 291c, 42 U.S.C. Sec. 291e(b)."[24] *Id.* at 25b, *citing* 42 U.S.C. Sec. 291e(b).

The fact remains, however, that in 1979, the Secretary promulgated regulations that substantially changed the agency's interpretation of the obligations from that which had existed for the previous 30 years. Therefore, judged solely by the Secretary's actions, the same statutory language is subject to two distinctly different interpretations. Language that is clear and unambiguous cannot be subject to such divergent interpretations.

The circuit court's reliance on Section 291e(b) is also inappropriate. Section 291e(b) governs the Secretary's approval of state Hill-Burton plans. First and foremost, Section 291e(b) applies, by its own terms, only to allocation applications by the states and not to individual hospitals seeking assistance. Second, the power of the Secretary to demand substantive conditions of hospitals is not increased in any degree by Section 291e(b). Third, the assurances given and the obligations assumed by individual Hill-Burton hospitals remain the same. Clearly, the court's reference to Section

[24] Interestingly, the Secretary failed to cite either 42 U.S.C. Sec. 291c or 42 U.S.C. Sec. 291e(b) as authority when he issued the Hill-Burton regulations in 1979.

291e(b), which contains no additional assurances applicable to grant or loan participants, must be discounted.

D. Assisted Hospitals Have Been Seriously Harmed by the 1979 Hill-Burton Regulations

The decision of the circuit court implies that hospitals have not been seriously harmed by the 1979 regulations' imposition of a required quota of uncompensated care services on hospitals which were assisted by Hill-Burton grants or loans. However, the court's implication is not substantiated by the facts.

The circuit court accepted, without discussion, the Secretary's contention that "[t]he financial burden of providing uncompensated services amounting to 10 percent of federal assistance received for twenty years is the same as the burden of repaying a loan over twenty years at 7-¾ percent interest, without some of the major risks a loan would ordinarily entail for the borrower." (App. B, *infra*, 18b, n.9.) The Secretary's figure for the effective average annual interest rate of accepting a Hill-Burton grant[25] would be correct only if there were no inflation. However, the 1979 regulations specifically provide that the dollar value of the care to be provided under the uncompensated care requirement must be adjusted by inflation. 42 C.F.R. Sec. 124.503(a)(1)(ii). Assuming an inflation rate of 7 percent, the effective average annual interest rate produced by the uncompensated care requirement of the 1979 regulations would be 20-⅛ percent, not the 7-¾ percent stated by the government and the court below.[26] Indeed, the effective rate

[25] The effective average annual interest rate for a Hill-Burton loan would be greater because interest payments would be required.

[26] The chart below, based on standard amortization tables, clearly shows the effective average annual interest rates, given various assumptions about inflation.

For the period between 1963 and 1982, the average annual increase in the medical care component of the Consumer Price Index for urban consumers was 7.38 percent, creating an effective average

Footnote continued on following page.

would be even higher if the value of uncompensated care provided through participation in the Medicare and Medicaid programs were included. In any event, it is clear that under the 1979 regulations the actual costs to hospitals of receiving Hill-Burton "assistance" through either grants or loans would be substantially in excess of the costs of obtaining loans from any private source.

The circuit court further argued that a comparison with private financing alternatives was inappropriate because adequate funds may not have been available from private lenders for hospital construction purposes during the period when the Hill-Burton program was operating. (App. B, *infra,* 18b.) However, the facts are to the contrary. Even in 1968, a year in which the Hill-Burton program was operating fully, over 75 percent of private, not-for-profit hospital construction was financed not by the government but by non-governmental sources.[27] By the early 1970s, when Congress reduced funds for the Hill-Burton program, hospitals increasingly began to obtain low-interest tax-exempt financing for their construction projects

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annual interest rate of more than 20-¼ percent during that period of time. The prime rate of interest in 1964 was 4.5 percent, and in 1971 was 5.7 percent. *See* App. A.

Inflation Assumption	Effective Average Annual Interest Rate
0%	7-3/4%
5%	15-3/4%
6%	17-7/8%
7%	20-1/8%
8%	22-5/8%
9%	25-3/8%
10%	28-1/2%

Prepared: American Hospital Association, January, 1984.

[27] AMERICAN HOSPITAL ASS'N, *Report of the Special Committee on Equity of Payment for Not-For-Profit and Investor-Owned Hospitals,* App. D at 5 (May 1983).

as an alternative to both government financing and commercial loans. In fact, by 1979 over half of the private, not-for-profit hospital construction projects in the United States were financed through tax-exempt bonds.[28]

Appendix A to this petition, derived from the trial court record, specifically demonstrates the adverse financial impact of various hospitals' decisions to accept assistance for construction under the Hill-Burton program rather than obtaining funds from private lenders or through tax-exempt bonds. Clearly, given the impact of the 1979 Hill-Burton regulations, the hospitals' previous acceptance of assistance from the Hill-Burton program made no economic sense, a fact to which numerous affidavits presented to the district court attest. There can be no question that had hospitals known the expanded obligations which were to be imposed upon them retroactively by the 1979 Hill-Burton regulations, few would have elected to participate in the Hill-Burton program.[29] As the affidavit of the

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[28] *Id.*

[29] *See, e.g.*, Affidavits in the district court of John E. Groskopf, Resurrection Hospital, Chicago, IL ("If Resurrection Hospital would have been aware of the conditions that were to be imposed some ten years after the [Hill-Burton] grant was originally contracted for, the Hospital would not have applied for the grant.")(A-97-103); of William R. Rundle, Wadsworth-Rittman Hospital, Wadsworth, OH ("When we entered into the agreement with Hill-Burton it was our understanding that the contract was pursuent [sic] to the then established standards. Had we known that these standards would change, we would not have signed such an agreement to receive a taxpayer's funded Hill-Burton grant.") (A-104-107); of Carl S. Napps, Winchester Memorial Hospital, Winchester, VA ("If the effect of the new regulations on the charges of Winchester Memorial Hospital had been known when the hospital made its decision to apply for a grant in 1961 and a Hill-Burton loan guarantee in 1976, the decisions would undoubtedly have been to finance both projects through conventional loans without the assistance of the Hill-Burton program.")(A-154-163).

executive director of one hospital points out, the members of his hospital's board of trustees, after the 1979 regulations were promulgated, became "well aware of their responsibilities and they find themselves frankly dismayed by the trap in which they were seduced through the lure of 'free' federal money."[30]

The nearly 3,700 not-for-profit or public hospitals which accepted Hill-Burton assistance find themselves in the same situation. These hospitals that had in good faith entered into agreements with the federal government to construct and modernize their facilities are now subject to onerous requirements which they could not have possibly foreseen when they accepted Hill-Burton assistance. The decision of the circuit court, upholding these additional regulatory conditions and quotas, ignores the principles of this Court's *Pennhurst* decision and works a gross inequity on this nation's health care providers.

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[30] Affidavit in the district court of Lowell J. Miller, Memorial Medical Center, Ashland, WI (A-67-73).

CONCLUSION

The 1979 Hill-Burton regulations misconstrue the language of the Hill-Burton statute, are contrary to the basic principles of contract law, and disregard legal principles associated with federal grant programs. Because of this, the writ of certiorari should issue.

Respectfully submitted.

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January 30, 1984

APPENDIX

OBLIGATIONS OF HOSPITALS UNDER THE 1979 HILL-BURTON REGULATIONS COMPARED WITH PRIVATE BORROWING SOURCES

Hospital	Amount of Assistance Sought	Year Hospital Applied for Assistance	Total Amount Payable by Hospitals Under Private Borrowing[a] (Principal Plus Interest)						Projected Total Hill-Burton Payout[e] (excluding additional administrative costs)
			Commercial Loans at Prime Rate[b]		Corporate Bond Yield[c]		Municipal Bond Yield[d]		
			Total Payment	(Rate)	Total Payment	(Yield)	Total Payment	(Yield)	
General Hosp. of Everett, Everett, WA. (A-149-155)	$2,600,000	1964	$4,000,000	(4.50)	$4,000,000	(4.47)	$3,561,644	(3.21)	$ 6,900,000
Resurrection Hosp., Chicago, IL. (A-97-103)	$1,500,873	1968	$2,677,739	(6.28)	$2,797,526	(6.84)	$2,291,409	(4.45)	$ 5,003,287
Bonner General Hosp., Sandpoint, ID. (A-73-77)	$ 813,034	1971	$1,383,888	(5.70)	$1,642,493	(7.85)	$1,355,057	(5.48)	$ 2,274,000
Norton-Children's Hosp., Louisville, KY. (A-89-96)	$4,500,000	1971	$7,659,574	(5.70)	$9,090,909	(7.85)	$7,500,000	(5.48)	$16,547,617

[a] Assumes a twenty year payout period with equal annual payments.

[b] The rate at which a bank lends money to its most favored business customers. Information provided by Statistical Indicators Division, Bureau of Economic Analysis, U.S. Dep't of Commerce.

[c] Rate of payment for taxable bonds. Information provided by Statistical Indicators Division, Bureau of Economic Analysis, U.S. Dep't of Commerce.

[d] Rate of payment for non-taxable bonds. Information contained in Bureau of Economic Analysis, U.S. Dep't of Commerce, "Historical Data For Selected Series," 23 Business Conditions Digest 99 (Oct. 1983).

[e] Projections contained in affidavits presented to the U. S. district court in this case.

Prepared: American Hospital Association, January, 1984.

In the

United States Court of Appeals

For the Seventh Circuit

No. 82-1295

AMERICAN HOSPITAL ASSOCIATION,

Plaintiff-Appellant,

v.

RICHARD S. SCHWEIKER, *et al.*,

Defendants-Appellees,

and

ILLINOIS MIGRANT COUNCIL, *et al.*,

Intervening Defendants-Appellees.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.
No. 79 C 2669—Nicholas J. Bua, *Judge.*

ARGUED OCTOBER 27, 1982—DECIDED NOVEMBER 1, 1983

Before CUDAHY and COFFEY, *Circuit Judges*, and WISDOM, *Senior Circuit Judge.**

CUDAHY, *Circuit Judge.* This case involves a challenge to certain regulations issued on May 18, 1979, by the

* The Honorable John Minor Wisdom, Senior Circuit Judge of the United States Court of Appeals for the Fifth Circuit, is sitting by designation.

Secretary of Health, Education and Welfare (now Health and Human Services) (the "Secretary") pursuant to Title VI (the "Hill-Burton Act") and Title XVI of the Public Health Service Act, 42 U.S.C. §§ 291, 300o *et seq.* (1976). The regulations, published at 42 C.F.R. § 124, Subparts F and G, impose specified obligations for community service and uncompensated care upon hospitals which received funds under the Hill-Burton Act. The American Hospital Association ("AHA"), on behalf of those hospitals, sued to have the 1979 regulations declared invalid, arguing that they violated statutory, contractual and constitutional rights. The district court granted summary judgment in favor of the Secretary. We affirm.

I

In 1946, in response to President Truman's call to enact legislation which would ensure adequate health care for all Americans, *see* President Truman's Message to Congress on Health Legislation, 1945 U.S. CODE CONG. SERV. 1143, Congress passed the Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946), presently codified as Title VI of the Public Health Service Act, 42 U.S.C. § 291. Title VI, commonly known as the Hill-Burton Act, was intended to address post-Depression and post-war problems with respect to the adequacy and distribution of health service facilities by means of a program of grants-in-aid to the states. *See* Statement of Senator Hill, *in* Hearings on S. 191 Before the Senate Comm. on Education and Labor, 79th Cong., 1st Sess. 6-9 (1945). The stated purpose of the Hill-Burton Act, in addition to the development and improvement of physical facilities and the promotion of research, was:

> to assist the several States in the carrying out of their programs for the construction and modernization of such public or other non-profit community hospitals and other medical facilities as may be necessary, in conjunction with existing facilities, to furnish adequate hospital, clinic, or similar services to all their people. . . .

42 U.S.C. § 291. States wishing to obtain the federal financial assistance—outright grants, loans and loan guaranties—were required to submit to the Surgeon General for his approval a state plan for carrying out the congressional purpose. 42 U.S.C. § 291d.

Most importantly to the issues involved in this litigation, the Hill-Burton Act provided that:

> The Surgeon General . . . shall by general regulations prescribe—
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> * * *
>
> (e) that the State plan shall provide for adequate hospitals, and other facilities for which aid under this part is available, for all persons residing in the State, and adequate hospitals (and such other facilities) to furnish needed services for persons unable to pay therefor. Such regulations may also require that before approval of an application for a project is recommended by a State agency to the Surgeon General for approval under this part, assurance shall be received by the State from the applicant that (1) the facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant; and (2) there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

42 U.S.C. § 291c(e).[1] Thus the statute required the state plan (1) to make provision for adequate health facilities

[1] This is the current version of the provision. The Hill-Burton Act was amended in 1964, but this assurances language remained substantially the same except for the elimination of language allowing provision of "separate but equal" facilities. The section deleted in 1964 read as follows:

(Footnote continued on following page)

for all persons residing in the state and (2) to furnish necessary services to persons unable to pay. The regulation or regulations which the Surgeon General (later the Secretary[2]) was directed to issue could require as a condition of approval of a project that the state give certain "assurances": (1) that the facility would be made available to all persons residing in the territorial area of the applicant and (2) that there would be made available in the facility a reasonable volume of services to persons unable to pay. These two assurances have become known, respectively, as the "community service assurance" and the "reasonable volume" or "uncompensated care assurance."

The regulations issued from 1947 to 1972 in implementation of this statutory provision essentially tracked the language of the statute, *see* 42 C.F.R. §§ 53.61-53.63 (Supp. 1947); and, although over $4.4 billion in grants and $2 billion in loans and loan guaranties were authorized between 1947 and 1974, *see* S. Rep. No. 1285, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. CODE CONG. & AD. NEWS 7860, the hospitals receiving aid displayed a marked reluctance to give even the most token charitable care. *See* Comment, *Provision of Free Medical Services by Hill-Burton Hospitals*, 8 Harv. C.R.-C.L. L. REV. 351, 352 (1973). After—and apparently in response to—a series of lawsuits brought by several private citizens and public

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[1] *continued*

> . . . [available to all persons] without discrimination on account of race, creed, or color, but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group. . . .

60 Stat. 1040, 1043.

[2] The Office of Surgeon General was abolished and this function was transferred in 1966 to the Secretary of Health, Education and Welfare. Reorg. Plan No. 3 of 1966, 31 Fed. Reg. 8855 (1966).

interest groups against federally assisted hospitals to enforce compliance with the Hill-Burton obligations, *see, e.g., Euresti v. Stenner*, 458 F.2d 1115 (10th Cir. 1972); *Cook v. Ochsner Foundation Hospital*, 61 F.R.D. 354 (E.D.La. 1972), the Secretary began in 1972 to issue regulations which defined standards for compliance with the assurances. These regulations specified what was to be deemed a "reasonable volume of services" in terms of a quantitative presumptive compliance level, defined "persons unable to pay," established standards for compliance with the community service assurance and initiated various reporting requirements to ensure compliance. *See* 42 C.F.R. §§ 53.111, 53.113 (1974).

In 1975 a new federal assistance program for hospital construction and modernization was established to replace Title VI. This later program, Title XVI of the Public Health Service Act, now codified at 42 U.S.C. § 300q *et seq.*, provides for assurances similar to those in Title VI but adds teeth to the Title VI requirements as well. Thus, Title XVI requires applicants for federal aid to give:

> reasonable assurance that at all times after such application is approved (i) the facility or portion thereof to be constructed, modernized, or converted will be made available to all persons residing or employed in the area served by the facility, and (ii) there will be made available in the facility or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the Secretary, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint.

42 U.S.C. § 300s-1(b)(1)(K). Apparently in recognition of the compliance problems which had arisen under the Hill-Burton program, Title XVI mandates, rather than permits, the Secretary to prescribe by regulation the manner in which all recipients of financial assistance under either Title VI or Title XVI "shall be required to comply with the assurances required to be made at the

time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances." 42 U.S.C. § 300s(3). The Secretary is also given extensive investigative and enforcement power by Title XVI. 42 U.S.C. § 300s-6.

The regulations which have given rise to the instant litigation were issued by the Secretary in response to this mandate. *See* 44 Fed. Reg. 29,372-29,410 (1979). The sections of the regulations relevant here are set forth in the Appendix to this opinion. Briefly, the 1979 regulations apply to all health facilities which gave assurances under either Title VI or Title XVI. The obligations under Title VI are made to continue for twenty years after the completion of construction or until the amount of the grant or loan is repaid,[3] 42 C.F.R. § 124.501(b)(1), although they have no retroactive application to the period prior to the effective date of the regulations. *See* 44 Fed. Reg. 29,372-29,374 (1979). In carrying out the uncompensated care assurance, Subpart F of the regulations sets a quantitative annual standard of compliance by requiring uncompensated care equal to the lesser of either 3% of the facility's operating cost for the last fiscal year or 10% of all federal assistance received by the facility, adjusted to make allowance for inflation for each year after 1979 (in effect prescribing the meeting of the obligation in the equivalent of 1979 dollars). 42 C.F.R. § 124.503(a). If in any year a facility is financially unable to meet this standard, the deficit may be made up in the following year, or in years subsequent to that, and, if necessary, at the end of the twenty-year period of obligation. 42 C.F.R. § 124.503(b). Excesses will similarly be applied as credits against subsequent years' obligations. 42 C.F.R. § 124.503(c). The regulations also specify that amounts received as reimbursement from insurance programs or under Medicare or Medicaid may not be counted in

[3] Obligations under Title XVI are not limited to any period of time, 42 U.S.C. § 300s-1(b)(1)(K), 42 C.F.R. § 124.501(b)(2).

computing the amount of uncompensated services rendered. 42 C.F.R. § 124.509.

With respect to the community service assurances, Subpart G of the regulations requires that the federally assisted health facilities be made available to all residents and prohibits the exclusion of anyone in the area served by the hospital on the basis of any factor unrelated to need. The facility may, however, deny services to individuals unable to pay for them if the facility is not required to accept these patients under the uncompensated care requirements of Subpart F. 42 C.F.R. § 124.603(a)(1). The regulations also specifically address certain denials of medical services which are impermissible. These denials include refusals to participate in the Medicare and Medicaid programs or discrimination against individuals who are recipients of aid under those programs. 42 C.F.R. § 124.603(c). The regulations also prohibit adherence to certain admissions policies which would have the effect of excluding individuals on impermissible grounds. 42 C.F.R. § 124.603(d). As an example of such prohibited practices, the regulations cite a policy of accepting only patients with private physicians who have staff privileges at the hospital. The rules require that the facility make alternative arrangements to ensure that its services are available to patients of this kind, and the regulations contain illustrative examples of such arrangements—the extension of temporary privileges to the person's physician; the referral of patients to a doctor with staff privileges; the establishment of a clinic through which such patients may be treated and, if necessary, admitted; the entering into contracts with qualified physicians and other arrangements. 42 C.F.R. § 124.603(d)(1). Similarly, if most physicians on the staff of a Hill-Burton hospital refuse to accept Medicare and Medicaid patients, so that beneficiaries of such aid are effectively excluded from admission, the hospital must establish alternative arrangements to make facilities available to such persons. 42 C.F.R. § 124.603(d)(2). The requirement of a preadmission deposit which acts to exclude otherwise eligible

individuals is also prohibited. 42 C.F.R. § 124.603(d)(3). The regulations also contain provisions regarding notice to patients of the facilities' obligations, reporting and record-keeping requirements and mechanisms for investigation and enforcement. 42 C.F.R. §§ 124.604-124.606.

On June 27, 1979, the AHA filed suit against the Secretary seeking to have the 1979 regulations enjoined, and moved on August 27, 1979, for a temporary restraining order. On August 31, 1979, the district court denied the motion for a temporary restraining order and granted leave to intervene as defendants to various individuals and public interest organizations concerned with health care, rights of welfare recipients and the status of migrant workers. On October 1, 1979, the AHA's motion for a preliminary injunction was also denied. On July 2, 1980, this court affirmed the denial of preliminary relief. *American Hospital Ass'n v. Harris*, 625 F.2d 1328 (7th Cir. 1980).

Thereafter, on September 24, 1980, the AHA filed a motion for summary judgment, and defendants subsequently filed cross-motions to the same effect. On January 8, 1982, the district court denied the AHA's motion and granted summary judgment in favor of the defendants. *American Hospital Ass'n v. Schweiker*, 529 F. Supp. 1283 (N.D.Ill. 1982). The AHA appeals from this denial, arguing, as it did below, that the 1979 regulations exceed the Secretary's statutory authority, that they violate contractual agreements between the federal government and the assisted hospitals by altering and expanding their obligations under those agreements and that they violate the due process clause by impairing the hospitals' contractual rights.

II

This case involves review of these administrative regulations pursuant to the Administrative Procedure Act, 5 U.S.C. §§ 701-706. No challenge has been raised to the procedural adequacy of the administrative proceeding. Setting aside for a moment the contractual and constitutional claims, which we shall discuss in Part III, *infra*, our

consideration is limited to certain specific questions. We must first inquire whether the Secretary, in promulgating the 1979 regulations, acted within the scope of his statutory authority. 5 U.S.C. § 706(2)(C); *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 415 (1971). If we conclude that he was so acting, the regulations cannot be set aside unless we find that they are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706 (2)(A); *Batterton v. Francis*, 432 U.S. 416, 426 (1977). Put another way, a reviewing court will sustain any regulation promulgated under a statute if it is "'reasonably related to the purposes of the enabling legislation.'" *Mourning v. Family Publications Service, Inc.*, 411 U.S. 356, 369 (1973), *quoting Thorpe v. Housing Authority of the City of Durham*, 393 U.S. 268, 280-81 (1969). This standard of review is highly deferential; it begins with a presumption that the agency action is valid and affirms the agency decision if it has any rational basis, thereby refusing to substitute the court's own judgment for that of the agency, *Ethyl Corp. v. Environmental Protection Agency*, 541 F.2d 1, 34 (D.C. Cir.), *cert. denied*, 426 U.S. 941 (1976).

We note, first of all, that the authority conferred upon the Secretary under the Hill-Burton Act is very broad. He was required to issue general regulations to ensure that the various state plans provide that the facilities established with the aid of federal funds be made available to all residents of the community and that they furnish services to persons unable to pay, 42 U.S.C. § 291c(e), and he was directed to approve only applications for aid which were in compliance with the regulations issued pursuant to his authority under section 291c, 42 U.S.C. § 291e(b)(2). Under the statutory scheme, therefore, Congress expressly delegated to the Secretary the authority to set standards of compliance with the Act's goals; in establishing these standards the Secretary engages in what is commonly called "legislative rulemaking." *See, e.g., Batterton v. Francis*, 432 U.S. at 425; 2 K. DAVIS, ADMINISTRATIVE LAW TREATISE § 7:8 (2d ed. 1979).

We think it is clear that the Secretary was acting within the scope of his statutory mandate[4] when he promulgated the regulations here. Although the AHA contends that the Hill-Burton Act was merely a construction statute with a non-discrimination clause attached, such a contention is difficult to reconcile with the specific statutory language requiring assurances that the facilities constructed be available to all residents and in particular to those unable to pay for medical services.

Moreover, the legislative history of the Hill-Burton Act, both in its origins and as it has evolved through amendment, indicates that it was intended to be more than a construction statute. Although the assurances were not in the original bill introduced by Senator Hill in 1945, Hearings on S. 191 Before the Senate Comm. on Education and Labor, 79th Cong., 1st Sess. 1-6 (1945) [hereinafter "1945 Hearings"], the records of the Senate hearings demonstrate that the provision of medical services to indigents was a recurrent theme. *See* 1945 Hearings at 177 (statement of Senator Murray); at 190, 212, 245 (remarks of Senator Ellender); at 30 (remarks of Senator Chavez). A particularly revealing colloquy took place among Senator Ellender, Senator Pepper, Senator Taft and Dr. Frederick D. Mott, an official of the Department of Agriculture, on March 12, 1945:

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[4] Although, as the appellant points out, the preamble to the 1979 regulations recites that they are issued under the authority of Title XVI, we do not think that this point is critical to our review of the Secretary's authority. First of all, Title XVI is in effect the successor statute to Title VI and specifically confers authority upon the Secretary to issue regulations prescribing the standards for compliance with the assurances given under Title VI as well. 42 U.S.C. § 300s(3). Since we find that the Secretary could have drawn his authority to issue the regulations here in question from either provision, the fact that Title XVI is named in the preamble to the regulations is not controlling.

Senator Taft. Let me suggest something else. You would say a hospital accepting aid of this kind should have an obligation to take care of a certain number of indigent patients. Most of them do, but I mean if they are going to have Federal money, should there not be a definite obligation to handle a certain number of indigent patients?

Dr. Mott. Senator, I would think there would certainly be an obligation to meet the needs of all the people of that hospital service area for which the hospital was designed, which would, of course, include many indigent and medically indigent.

* * *

Senator Pepper. This is what occurred to me, Senator . . . that in determining the burden which the hospital would be expected to carry, they might not be able to get Federal aid unless they agreed to take a fixed number of indigent patients.

Senator Taft. That is what I mean. I imagine every hospital of a general nature would be lucky if they did not have 20 percent of indigent patients.

* * *

Senator Ellender. If people in all localities were able to pay for hospitalization there would be no need for this bill. It seems to me that our primary purpose should be to devise means to take care of those who cannot take care of themselves. My reason for supporting a bill providing for Federal aid to build hospitals is to make it easy for the community in which a hospital may be built to give aid to the indigent. . . .

Senator Taft. My interest in it is like in a public works bill, just to provide construction. But beyond that, these facilities must be made available to the people.

1945 Hearings at 190-91. This discussion indicates that provision of medical services for the indigent was a major concern among supporters of the bill; it also points out the

contemporary assumption that hospitals would voluntarily provide charitable services at low or no cost to the poor. The hospitals' compliance with the assurances which were later inserted into the bill may well have been taken for granted, once the federal government enabled them to construct facilities.

The provision adding the community service and uncompensated care obligations to the Hill-Burton Act first appeared in late 1945 in the report of a subcommittee of the Senate Committee on Education and Labor; the subcommittee was made up of Senators Hill, Ellender, Taft, Tunnell and LaFollette. Senate Comm. on Education and Labor, S. Rep. No. 674, 79th Cong., 1st Sess. 9, 17 (1945). The subcommittee described the changes from the original bill, changes which included the assurances, as authorizing "Federal regulatory powers . . . consistent with effective Federal control of appropriated moneys." *Id.* at 8. Neither the committee nor the Congress discussed these provisions in further detail at that time.[5]

In any event, one may infer from the provisions' mere presence in the statute that the free care obligation was intended to have some effect. Moreover, the very fact that the Act authorized an exception to the obligation to provide uncompensated care, if a facility was financially unable to furnish it, indicates that the Act contemplated that the hospital would be required to devote some of its own resources to fulfilling the assurances. *See* Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 Yale L.J. 243, 267 (1978).

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[5] It is commonly believed that the obligations were added as concessions to Senate "liberals" who had been unsuccessful in their attempt to include national health insurance in the proposed health package. Roce, *Federal Regulation of Services to the Poor under the Hill-Burton Act: Realities and Pitfalls*, 70 Nw. U. L. Rev. 168, 170 (1975); Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 Yale L. J. 243, 266 (1978); *cf.* Comment, *Due Process for Hill-Burton Assisted Facilities*, 32 Vand. L. Rev. 1469, 1478 (1979).

The only change in the statutory language describing these obligations occurred in 1964 when Congress amended the provision so as to eliminate both the clause allowing "separate but equal" facilities and the clause describing the community service obligation as an availability "without discrimination on account of race, creed or color." At that time, the Secretary argued for continued inclusion of the language about discrimination so as to limit the availability prescribed by the community service assurance to a ban on certain types of discrimination, but Congress specifically rejected the proposed limiting language. *See* Hearings on H.R. 10041 Before the House Comm. on Interstate and Foreign Commerce, 88th Cong., 2d Sess. 53-54, 67, 90-92 (1964).

The premise, assumed in 1945, that hospitals would voluntarily provide services to all residents, including the indigent, out of their history of charitable service, proved to be unjustified; their apparent failure resulted in litigation to enforce the federally assisted hospitals' community service and uncompensated care obligations in the early 1970s. *See, e.g., Corum v. Beth Israel Medical Center*, 359 F. Supp 909 (S.D.N.Y. 1973); *Euresti v. Stenner*, 458 F.2d 1115 (10th Cir. 1972); *Cook v. Ochsner Foundation Hospital*, 319 F. Supp. 603 (E.D.La. 1970). The regulations which were issued in 1972 and 1974 were to some extent a response to this litigation. For the first time, they set specific standards for compliance with the hospitals' obligations—standards which are in many respects similar to the ones embodied in the 1979 regulations at issue here.[6] *See* 42 C.F.R. §§ 53.111, 53.113 (1974).

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[6] For example, the 1972 regulations included presumptive standards for annual compliance at a level of 3% of operating costs or 10% of assistance under the Act, 42 C.F.R. § 53.111(d); the 1974 regulations required facilities to participate in Medicare and Medicaid and not to exclude or discriminate against beneficiaries of those programs from medical services, 42 C.F.R. § 53.113(d) (1974).

Congress passed Title XVI in 1975, after the passage of the more stringent regulations under Title VI. The new act, which replaced the Hill-Burton program, contained language requiring assurances almost identical to those required by Title VI, but the 1975 provisions were mandatory upon the Secretary and supported by ample investigatory and enforcement mechanisms. *See* 42 U.S.C. §§ 300s-1(b)(1)(K), 300s-6. The Senate report indicates that the inclusion of these stronger provisions, and the extension of their application to facilities which had received funds under Title VI as well, was the result of a conviction that the Secretary, state agencies and health care facilities had all been deplorably lax in complying with the community service and uncompensated care obligations:

> . . . the GAO report states that "the implementation of the free service requirement is in its infancy at the State agency and local facility level." It states that "while the State plans reviewed contained provisions which essentially met the Federal requirements, none of the State agencies had an active program for monitoring compliance with the requirement. Most intend to rely on complaints to monitor compliance. Also, some facilities have not informed the State agencies how they intend to meet the reasonable volume of free services requirement." This seems to the Committee to be a sorry performance by the Department and the State Hill-Burton agencies in implementing a provision which has been in law for over 20 years, and which has recently been reemphasized.

Senate Comm. on Labor and Public Welfare, S. Rep. No. 1285, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. CODE CONG. & AD. NEWS 7842, 7900. Moreover, Congress reaffirmed its insistence upon compliance with the assurances in 1979, after the regulations before us had been passed.[7]

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[7] "The committee wishes to reaffirm its previous position that services at facilities constructed or modernized, in whole or in

(Footnote continued on following page)

See Senate Comm. on Labor and Human Resources, S. Rep. No. 96, 96th Cong., 1st Sess., *reprinted in* 1979 U.S. CODE CONG. & AD. NEWS 1306, 1396.

This rather detailed account of the legislative history of the provision before us provides abundant evidence that Congress—both in 1946 and in 1975—strongly intended that the words of the statutory assurances be given a practical reality, with the result that facilities receiving funds under the federally assisted programs would indeed "be made available to all persons residing in the territorial area of the applicant . . . [including] a reasonable volume of services to persons unable to pay. . . ." 42 U.S.C. § 291c(e). We hold, therefore, that the Secretary was acting within his statutorily prescribed authority in promulgating the 1979 regulations at issue here.

Having found that the Secretary was acting within the general scope of his statutory authority in issuing these regulations, our review is restricted to inquiring, in the first instance, whether the regulations violate any of the explicit statutory limits upon the scope of the facilities' obligations. As the district court noted, the only limitations upon the scope of the assurances which the Secretary was authorized to require are (1) that the persons to whom services must be made available are those who reside in the territorial area, (2) that the amount of services required be a "reasonable volume," (3) that the assurances apply only to the facility or portion thereof to be constructed or modernized and (4) that an exception to the uncompensated care requirement be made where it is financially infeasible for the health care provider to

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[7] *continued*

part, with the aid of Federal funds under Title VI or Title XVI will, in fact, be accessible to all members of the community in which the facility is located, including (to the extent financially feasible) persons unable to pay. . . . Accordingly, the committee expects that the Secretary will implement and enforce compliance with these assurance [sic] as vigorously and expeditiously as possible." 1979 U.S. CODE CONG. & AD. NEWS at 1396.

comply. *American Hospital Ass'n v. Schweiker*, 529 F. Supp. at 1288-89. Section 291m of Title VI also states that "[e]xcept as otherwise specifically provided, nothing in this subchapter shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility. . . ." 42 U.S.C. § 291m. If we find that the regulations complained of do not violate any of these limitations, then our review under the Administrative Procedure Act is confined to inquiring whether they are arbitrary and capricious, 5 U.S.C. § 706(2)(A), (C); *Batterton v. Francis*, 432 U.S. at 426—or, affirmatively stated, whether they bear a rational relationship to the purposes of the statute, *Thorpe v. Housing Authority of the City of Durham*, 393 U.S. 268, 280-81 (1969). We shall examine each of AHA's allegations under these standards.

Compliance Levels

The AHA challenges the compliance levels set in 42 C.F.R. § 124.503(a) on several accounts. In most general terms, it is alleged that the percentages set forth by the Secretary do not define a "reasonable volume of services" within the meaning of the statute. The 10% of assistance figure is challenged as unreasonably high and the addition of both an inflation factor and of other federal assistance programs to the base amount upon which the 10% is calculated is attacked as arbitrary. The alternative compliance standard—3% of operating costs for the year—bears, the AHA argues, no rational relationship to the amount of funds borrowed, is entirely arbitrary and includes in its base costs related to parts of the facility unassisted by the Hill-Burton program. More generally, the AHA apparently also believes that the elimination of the "open door option" included in previous versions of the regulations exceeds the Secretary's authority.

There is ample support in the record for the conclusion that the "open door option" (under which an assisted facility would merely certify that it would not exclude persons from admission based on inability to pay) did not

work. The records of the public hearings held on December 5-6, 1978, are replete with examples of persons turned away from Hill-Burton hospitals, of refusals to offer uncompensated services and of numerous administrative complaints involving hospitals that had selected the open door option.[8] In acting to restrict the hospitals to a choice of specified quantitative compliance levels, therefore, the Secretary was not only acting within his statutory authority to define what constituted a "reasonable volume of services" but was also responding to manifestations of Congressional discontent with past failure to monitor and enforce the statutory assurances. *See supra* at 15-16.

The Secretary's conclusion that it was necessary, in order to monitor compliance with the assurances, to rely on some finite measure of the "reasonable volume of services" required is rationally related to the statutory goal of assuring access by the indigent to the federally assisted facilities. In determining the precise level which reflects that "reasonable volume," this court may not substitute its own idea of reasonableness for that of the agency unless the regulation is clearly inconsistent with the purposes of the Hill-Burton Act. *Lugo v. Simon*, 426 F. Supp. 28, 35 (N.D. Ohio 1976). We find no such inconsistency here.

Appellants' arguments to the contrary appear to be based upon a conception of the Hill-Burton program as a relationship between the hospital as a private debtor and the government as a commercial lender entitled merely to a market rate of return upon capital. Thus they complain about the addition of an inflation factor to the 10% of assistance level and the inclusion of other federal assistance in the base amount, or, alternatively, about the use of operating costs of the entire facility rather than of the assisted portion alone. But the 1946 program was not simply

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[8] *See, e.g.*, December 5, 1978 Hearing, Record at 27-32, 43-45, 76-85; December 6, 1978 Hearing, Record at 131, 133-36, 161-67, 186-87, 263-65, 297-98.

a commercial lending transaction; rather, it was a program, having broad public implications, under which Congress extended aid for the construction of hospitals and expected those hospitals in return to offer services to all the residents in their communities, including those who were indigent. When this expectation was not met, percentage compliance amounts were established. But those amounts, it is important to remember, do not constitute a loan repayment schedule;[9] they are instead a rough means of monitoring compliance with the obligation to provide uncompensated care. Objections based upon inclusion of other federal programs or of total operating costs in the base amount, within the limits presented here, are not persuasive. Moreover, the inflation factor is a rational means of preserving a real dollar amount as a reasonable measure of the *volume of services* which the facilities are expected to provide. It is the actual amount of services provided, in short, that is the indicator of compliance with the facilities' assurances—and not the nominal dollar cost or value of those services. Since we are not persuaded that the presumptive compliance levels are an unreasonable method to measure that compliance, we must uphold the presumptive compliance regulations.

Denial of Credit for Medicaid "Shortfall"

As a related matter, the AHA challenges the regulation codified at 42 C.F.R. § 124.509(b), which prohibits hospitals from crediting against their uncompensated care obligation the difference between the cost of care for a patient and the amount actually reimbursed under the Medicaid

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[9] Of course, there is no showing that adequate funds would have been available from private sources in lieu of the Hill-Burton program. In addition, the Secretary contends that, "The financial burden of providing uncompensated services amounting to 10 percent of federal assistance received for twenty years is the same as the burden of repaying a loan over twenty years at 7 3/4 percent interest, without some of the major risks a loan would ordinarily entail for the borrower." Secretary's Brief at 21 n. *.

program, which may be less than actual cost. We note, first of all, that the regulation which mandates participation in the Medicare and Medicaid programs by all Hill-Burton hospitals, 42 C.F.R. § 124.603(c), not only is virtually identical to that contained in the earlier regulations, *see* 42 C.F.R. § 53.113(d)(2), but also represents a codification of case law under the community service obligation. *Cook v. Ochsner Foundation Hospital*, 61 F.R.D. 354, 359-60 (E.D. La. 1972). Moreover, as we recently said with respect to the relationship between the Medicare Act and the Hill-Burton Act—a relationship similar in this regard to that between the Hill-Burton and Medicaid Acts—the two are separate and distinct federal programs with distinct goals and obligations. *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F.2d 1337, 1343 (7th Cir. 1983). The fact that reimbursement under the Medicaid program may fall short of cost is a problem that Hill-Burton hospitals share with all other hospitals participating in Medicaid. It is neither reasonable nor just that Hill-Burton hospitals should fare better in relation to this problem than do hospitals which have received no federal assistance under the program.[10]

The Exception for Financial Infeasibility

The AHA argues that the 1979 regulations violate the statutorily mandated exception for financial infeasibility by deferring rather than waiving compliance with the uncompensated care obligation for the year when the facility is financially unable to comply. 42 C.F.R. § 124.503(b). The exact nature of the financial infeasibility exception, however, is unclear from the language of the statute, which appends the phrase "but an exception shall be made if such a requirement is not feasible from a financial viewpoint" to the provision authorizing the Secretary to re-

[10] If the shortfall were permitted to be credited against the Hill-Burton obligation, the credit could (and the Secretary argues that it probably would) swallow up the uncompensated care obligation entirely.

quire the "assurances" from all applicants for aid. 42 U.S.C. § 291c(e). The Secretary argues that this exception applies only at the point of the initial application and grant. Without deciding this question, we do note that the statute does not mandate a total waiver of the uncompensated care obligation when a facility is unable to pay. The 1979 regulations instead deal with financial infeasibility by allowing the facility to defer compliance with the uncompensated care assurance until it is financially able to provide the care required. We cannot say that this is an arbitrary method of dealing with the issue; indeed, it seems eminently fair to the recipients of the aid, allowing them to extend repayment of their obligation without penalty.

The AHA further argues that thus to extend the obligation violates the 20-year limitation on the Hill-Burton uncompensated care obligation. This 20-year limitation is not explicitly incorporated in the statute,[11] but was judicially engrafted onto it as representing a reasonable period of time over which to require the provision of uncompensated services, as measured by the compliance standards included in the 1972 regulations. *Lugo v. Simon*, 426 F. Supp. 28, 35 (N.D. Ohio 1976).[12] These standards were expressed as percentages which were virtually identical to those in the 1979 regulations before us. If a facility provides uncompensated care in that volume, the deficit carry-over provision will not extend the obligation beyond twenty years; it is only a repeated failure to comply which will have that effect. Thus the 20-year durational limit is just a part of the formula for

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[11] There is a 20-year limit upon the period during which the government may recover a portion of the aid if the hospital is sold to a person not eligible for Hill-Burton assistance or ceases to be a non-profit institution, 42 U.S.C. § 291i; but this recapture provision has little relevance to the duration of the Hill-Burton facilities' assurances.

[12] The community service obligation, on the other hand, is perpetual. *Lugo v. Simon*, 426 F. Supp. at 36.

measuring a reasonable *volume* of services in terms of a certain percentage of assistance or of costs over a finite period of time. If a facility is financially unable to meet this obligation in any year, allowing an open-ended period during which to render the services ensures that a "reasonable volume of services" will be provided over time—at a rate possible for the individual facility. We cannot say that this arrangement is an unreasonable way to implement the financial infeasibility exception. We therefore uphold the deficit carry-over provision embodied in 42 C.F.R. § 124.503(b).

Prohibition of Exclusionary Admissions Policies

The AHA argues that the various regulations affecting hospital admissions policies violate the statutory prohibition against federal control over the administration and operation of hospitals and the conduct of physicians. *See* 42 U.S.C. § 291m. The particular regulations under challenge in this respect are those which prohibit certain admissions policies having the effect of excluding persons on impermissible grounds: exclusion of patients who do not have a doctor with staff privileges, exclusion of Medicaid patients because few or none of the staff physicians treat Medicaid patients and the requirement of a pre-admission deposit. 42 C.F.R. § 124.603(d). If these policies should apply, the regulations require that an assisted facility make other arrangements so that individuals excluded by these policies may be treated; various alternatives are suggested, such as referrals to physicians on the staff, establishing a clinic or extending temporary privileges to non-staff physicians. However, the alternatives are offered only as suggestions; the only mandate is the prohibition of certain practices if their effect is exclusionary.

We find the argument that such a prohibition constitutes supervision or control over the administration of a hospital to be most implausible. The practices in question are cause for concern only if their effect is exclusion on impermissible grounds of persons needing medical care. If exclusion is the result, the hospitals must make other arrangements, but no particular solution is imposed. To

the extent that these prohibitions circumscribe freedom of the facilities to run their affairs entirely as they wish, we note that the restriction in Section 291m upon such interference is qualified by the phrase "[e]xcept as otherwise specifically provided." 42 U.S.C. § 291m. Section 291c(e), which requires that assisted facilities be made available to all residents, is just such a specific exception. *Wyoming Hospital Ass'n v. Harris*, 527 F. Supp. 551, 560 (D. Wyo. 1981). We conclude that the challenged regulation, 42 C.F.R. § 124.603(d), does not violate the statutory prohibition contained in 42 U.S.C. § 291m. Since there is, moreover, abundant evidence in the record that the three prohibited practices did in fact prevent many otherwise eligible persons from receiving care at Hill-Burton facilities,[13] we cannot set these provisions aside as arbitrary and capricious.[14]

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[13] *See, e.g.*, December 5, 1978 Hearing, Record at 17-26, 308-14; December 6, 1978, Hearing, Record at 129-30, 157-59.

[14] The AHA also argues that the regulations impermissibly extend the Hill-Burton hospitals' obligation to the entire facility by dictating admissions policies applicable to the entire facility and by requiring the provision of emergency services in the unassisted portions of the facility. These arguments seem to be based on an erroneous assumption that the regulations require more than they actually do. The regulations, including the prohibition on exclusionary admissions policies and governing the provision of emergency services, explicitly include the statement that the facility must make the services available "in the facility or portion thereof constructed." 42 C.F.R. § 124.603(a)(1). Provision of emergency services according to the source of construction funds for the particular area which proves to be required by the patient may also simply not be feasible. The AHA argues, in addition, that the facilities' obligations are extended beyond the assisted portion by using the operating costs of the entire facility as the base amount for the 3% compliance level. However, the computation of the 3% compliance level upon total operating costs has nothing whatever to do with the portion of the hospital in which services are to be provided. If the amount of federal assistance is small, moreover, in relation to operating costs of the entire facility,

(Footnote continued on following page)

III

We turn now to the contractual and constitutional challenges to the 1979 regulations. The AHA alleges that the regulations impermissibly impair the assisted hospitals' contractual rights by adding conditions to which the hospitals did not assent at the time they entered into their agreements with the government; this impairment of contract rights and retroactive alteration of the hospitals' obligations, according to the AHA, constitute a violation of the facilities' rights under the due process clause of the Fifth Amendment. Since these two arguments are closely related, we will deal with them together.

In support of their argument based on impairment of contract rights, the AHA cites to us, first, cases standing for the proposition that the United States government must honor the terms of the contracts into which it has entered. *See, e.g., Lynch v. United States*, 292 U.S. 571, 580 (1934). With respect to this argument, we note, first of all, that the relationship between the government and the hospitals here cannot be wholly captured by the term "contract" and the analysis traditionally associated with that term. Rather than a voluntary agreement negotiated between two parties, a grant-in-aid program like that under the Hill-Burton Act is an exercise by the federal government of its authority under the spending power to bring about certain public policy goals. The government acts by inducing a state or private party to cooperate with the federal policy by conditioning receipt of federal aid upon compliance by the recipient with federal statutory and administrative directives. *See Fullilove v. Klutznick*, 448 U.S. 448, 474 (1980). The "conditions" of this arrangement are not the result of a negotiated agreement between the parties but rather are provided by the statute under which the program is administered.

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[14] *continued*
the hospital may, and probably will, elect the 10% of assistance compliance level, since it will be the lesser of the two alternatives.

Determination of statutory intent, therefore, is of more relevance to the interpretation of these conditions than is an inquiry into the intent of the two parties at the moment of the initial agreement. The contract analogy thus has only limited application.

Moreover, there is case law arising out of litigation engendered by the vast growth of governmental regulatory activity in the 1930s and thereafter, which provides precedents strongly supporting the government's right, when undertaking a regulatory scheme, to alter the expectations and obligations of private parties. *See, e.g., FHA v. The Darlington, Inc.*, 358 U.S. 84 (1958); *Thorpe v. Housing Authority of the City of Durham*, 393 U.S. 268 (1969); *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1 (1976). To the extent that such regulation is considered to be "retroactive,"[15] these cases nonetheless uphold its constitutionality.

Rejecting these precedents, the AHA instead relies heavily upon certain language in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981):

> [L]egislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the "contract." There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously.

451 U.S. at 17 (citations omitted). But *Pennhurst* is quite different from the case at hand. *Pennhurst* addressed the question whether a new federal statute—the "bill of

[15] The regulations here are, in a strict sense, prospective, in that they apply only to the unexpired years of any hospital's 20-year obligation.

rights" provision of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6010(1) and (2), which involved federal grants to assist participating states create programs for the developmentally disabled, conferred an enforceable substantive right upon mentally retarded persons. *Id.* at 5. The case before us, on the other hand, involves not *whether* enforceable obligations were created by the Hill-Burton Act—that is conceded—but rather the scope and interpretation of those obligations. Again, this question is one more of statutory construction than of contract law.

Even assuming for the moment the contractual nature of the obligations at issue here, and the applicability of the *Pennhurst* principles to them, we conclude without difficulty that the 1979 regulations do not violate those principles. The "contracts" entered into here consisted not only of the forms signed by the applicants for aid (on which general statements of the assurances were printed) but also of the statutory obligation under 42 U.S.C. § 291c(e). *See Euresti v. Stenner, supra*, 458 F.2d at 1118. Understanding the contract as incorporating the statutory terms, it is plain that the conditions imposed upon recipients of Hill-Burton aid were unambiguously stated: (1) they were required to make the facilities available to all persons residing in the area and to furnish necessary services to persons unable to pay, 42 U.S.C. § 291c(e); (2) the Secretary was authorized to issue general regulations requiring assurances that the facilities would comply with these two obligations, if they were financially able to do so, 42 U.S.C. § 291c(e); and (3) the applicants were required to comply with whatever regulations were issued pursuant to section 291c, 42 U.S.C. § 291e(b). Thus, in consideration of the federal financial assistance, the recipients agreed to a substantial amount of federal regulation and, in particular, to provide adequate services to their respective communities, including uncompensated care, while the right to specify the measure of these obligations was conferred upon the Secretary. In short, the applicants for Hill-Burton funds signed a very open-ended "contract," one which conferred

a great deal of discretion upon the Secretary to define the precise measure of their obligations under it.

The situation in the case before us is, we think, almost an exact parallel to that in *The Darlington*, *supra*. In that case, the appellee corporation had obtained FHA mortgage insurance in 1949 to construct an apartment house; when the 1954 Housing Act prohibited the rental of this housing to transients, the corporation sued the FHA. The Supreme Court found that this restriction on the use of the property, although not contained in the 1946 statute under which the aid had been sought and received, was nonetheless within the purpose of that statute, was consistent with administrative construction of the act and was also within the construction placed upon the prior act by a subsequent Congress. Thus the 1954 provision was held to be constitutional in its application to persons who had received mortgages under the prior statute. 358 U.S. at 90-91. In passing the later statute, the Court concluded, Congress was merely "protecting the regulatory system which it had designed." 358 U.S. at 91. Such an analysis has also been explicitly applied to regulations issued pursuant to statutes as well as to subsequent statutory provisions. *See Thorpe v. Housing Authority of the City of Durham*, 393 U.S. 268 (1969).

The Darlington is directly on point here, where we have found the 1979 regulations to have been within the purpose of the Hill-Burton Act as well as within the interpretation of it by a later Congress. *See supra* at 11-18. Nor can the appellees be said to have gained any vested rights arising during the years in which the Hill-Burton obligations were laxly enforced by the Secretary. In the words of *The Darlington* Court:

> Those who do business in the regulated field cannot object if the legislative scheme is buttressed by subsequent amendments to achieve the legislative end.

358 U.S. at 91. We find, therefore, that no rights of the appellees, protected either under contract or under the due process clause, have been violated by the promulgation and enforcement of the 1979 regulations. The judgment of the district court is therefore AFFIRMED.

APPENDIX

Subpart F — Reasonable Volume of Uncompensated Services to Persons Unable to Pay

* * * *

§ 124.503 Compliance level.

(a) *Annual compliance level.* (1) A facility is in compliance with its assurance to provide a reasonable volume of services to persons unable to pay if it provides for the fiscal year uncompensated services at a level not less than the lesser of —

(i) Three percent of its operating costs for the most recent fiscal year for which an audited financial statement is available; or

(ii) Ten percent of all Federal assistance provided to or on behalf of the facility, adjusted by a percentage equal to the percentage change in the national Consumer Price Index for medical care between the year in which the facility received assistance or 1979, whichever is later, and the most recent year for which a published Index is available. For purposes of this paragraph, the Federal assistance in the case of a loan which is guaranteed or made and sold by the Secretary will be deemed to have been provided in the year in which the Secretary made the loan.

(b) *Deficit in compliance* — (1) *Facilities assisted under Title VI*—If in any fiscal year a facility assisted under Title VI of the Act fails to meet its annual compliance level, it shall provide uncompensated services in an amount sufficient to make up that deficit (as adjusted under paragraph (d)). The facility may make up a deficit at any time during its period of obligation or in the year or years (if necessary) immediately following, except where the facility failed to provide uncompensated services at the required level although financially able to do so, or where the facility did not comply with the requirements of this subpart.

(2) *Facilities assisted under Title XVI.* If in any fiscal year a facility assisted under Title XVI of the Act fails to meet its annual compliance level but has otherwise complied with the requirements of this subpart, the amount of uncompensated services provided in that year constitutes compliance with this subpart.

(c) *Excess compliance.* (1) Whenever a facility provides in a fiscal year uncompensated services in an amount exceeding its annual compliance level, it may apply the amount of excess (as adjusted under paragraph (d)) to reduce its annual compliance level in any subsequent fiscal year. The facility may use any excess amount to reduce its annual compliance level only if the services in excess of the annual compliance level are provided in accordance with the requirements of this subpart.

(2) A facility assisted under Title VI may in any fiscal year apply the amount of excess credited under this paragraph to satisfy the remainder of its obligation to provide uncompensated services. In any fiscal year, the amount of uncompensated services required to satisfy the remainder of the facility's obligation is its annual compliance level for that fiscal year provided multiplied by the number of years remaining in its period of obligation, plus any deficits required to be made up under this section.

(d) *Calculation and adjustment of deficit and excess.* (1) The amount of a deficit or excess in uncompensated services in any fiscal year is the difference between the facility's annual compliance level for that year and the amount of uncompensated services the facility provided in that year.

(2) The amount of any deficit the facility makes up, and the amount of any excess compliance applied to reduce a facility's annual compliance level, must be adjusted by a percentage equal to the percentage change in the National Consumer Price Index for medical care between the fiscal year in which the facility had a deficit or provided the excess, and the fiscal year in which the facility makes up

the deficit or applies the excess to reduce its annual compliance level or satisfy its remaining obligations.

* * *

§ 124.509 Exclusions from uncompensated services.

A facility may not include the following in computing the uncompensated services it provides:

(a) Any amount that the facility has received, or is entitled to receive, from a third party insurer or under a governmental program, except where the person to whom the facility provides services refused to take reasonable actions necessary to obtain the entitlement.

(b) Any amount in excess of the payment that the facility has received, or is entitled to receive, from a third party insurer or under a governmental program where the facility has agreed or is otherwise required to accept this payment as payment in full for the services;

(c) Any amount for services provided 96 hours or more following notification to the facility by a professional standards review organization (PSRO) that the PSRO disapproved the services under section 1155(a)(1) of the Social Security Act; and

(d) Any amount for which reimbursement would be available under a governmental program (such as medicare or medicaid) in which the facility, although eligible to do so, and required by § 124.603(c)(1) to do so, does not participate.

* * *

Subpart G — Community Service

* * *

§ 124.603 Provision of services.

(a) *General.* (1) In order to comply with its community service assurance, a facility shall make the services provided in the facility or portion thereof constructed, modernized, or converted with Federal assistance under

Title VI or XVI of the Act available to all persons residing (and, in the case of facilities assisted under Title XVI of the Act, employed) in the facility's service area without discrimination on the ground of race, color, national origin, creed, or any other ground unrelated to an individual's need for the service or the availability of the needed service in the facility. Subject to paragraph (b) (concerning emergency services) a facility may deny services to persons who are unable to pay for them unless those persons are required to be provided uncompensated services under the provisions of Subpart F.

* * *

(c) *Third party payor programs.* (1) The facility shall make arrangements, if eligible to do so, for reimbursement for services with:

(i) Those principal State and local governmental third-party payors that provide reimbursement for services that is not less than the actual costs, as determined in accordance with accepted cost accounting principles; and

(ii) Federal governmental third-party programs, such as medicare and medicaid.

(2) The facility shall take any necessary steps to insure that admission to and services of the facility are available to beneficiaries of the governmental programs specified in paragraph (c)(1) of this section without discrimination or preference because they are beneficiaries of those programs.

(d) *Exclusionary admissions policies.* A facility is out of compliance with its community service assurance if it uses an admission policy that has the effect of excluding persons on a ground other than those permitted under paragraplh (a) of this section. Illustrative applications of this requirement are described in the following paragraphs:

(1) A facility has a policy or practice of admitting only those patients who are referred by physicians with staff privileges at the facility. If this policy or practice has the

effect of excluding persons who reside (or for Title XVI facilities, are employed) in the community from the facility because they do not have a private family doctor with staff privileges at the facility, the facility would not be in compliance with its assurance. The facility is not required to abolish its staff physician admissions policy as a usual method for admission. However, to be in compliance with its community service assurance it must make alternative arrangements to assist area residents who would otherwise be unable to gain admission to obtain services available in the facility. Examples of alternative arrangements a facility might use include:

(i) Authorizing the individual's physician, if licensed and otherwise qualified, to treat the patient at the facility even though the physician does not have staff privileges at the facility;

(ii) For those patients who have no physician, obtaining the voluntary agreement of physicians with staff privileges at the facility to accept referrals of such patients, perhaps on a rotating basis;

(iii) If an insufficient number of physicians with staff privileges agree to participate in a referral arrangement, requiring acceptance of referrals as a condition to obtaining or renewing staff privileges;

(iv) Establishing a hospital-based primary care clinic through which patients needing hospitalization may be admitted; or

(v) Hiring or contracting with qualified physicians to treat patients who do not have private physicians.

(2) A facility, as required, is a qualified provider under Title XIX medicaid program, but few or none of the physicians with staff privileges at the facility or in a particular department or sub-department of the facility will treat medicaid patients. If the effect is that some medicaid patients are excluded from the facility or from any service provided in the facility, the facility is not in compliance with its community service assurance. To be in compliance a facility does not have to require all of its staff physicians

to accept medicaid. However, it must take steps to ensure that medicaid beneficiaries have full access to all of its available services. Examples of steps that may be taken include:

(i) Obtaining the voluntary agreement of a reasonable number of physicians with staff privileges at the facility and in each department or sub-department to accept referral of medicaid patients, perhaps on a rotating basis:

(ii) If an insufficient number of physicians with staff privileges agree to participate in a referral arrangement, requiring acceptance of referrals as a condition to obtaining or renewing staff privileges;

(iii) Establishing a clinic through which medicaid beneficiaries needing hospitalization may be admitted; or

(iv) Hiring or contracting with physicians to treat medicaid patients.

(3) A facility requires advance deposits (pre-admission or pre-service deposits) before admitting or serving patients. If the effect of this practice is that some persons are denied admission or service or face substantial delays in gaining admission or service solely because they do not have the necessary cash on hand, this would constitute a violation of the community service assurance. While the facility is not required to forego the use of a deposit policy in all situations, it is required to make alternative arrangements to ensure that persons who probably can pay for the services are not denied them simply because they do not have the available cash at the time services are requested. For example, many employed persons and persons with other collateral do not have savings, but can pay hospital bills on an installment basis, or can pay a small deposit. Such persons may not be excluded from admission or denied services because of their inability to pay a deposit.

No. 82-1295 33

A true Copy:
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Clerk of the United States Court of Appeals for the Seventh Circuit

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

AMERICAN HOSPITAL ASSOCIATION,
Plaintiff,

vs.

RICHARD S. SCHWEIKER, et al.,
Defendants.

No. 79 C 2669

Before the Honorable
Nicholas J. Bua

MEMORANDUM OPINION

This cause comes before the court on motions for summary judgment, brought by all parties pursuant to F.R.Civ. P. 56. There being no disputed questions of material fact, the motions will be dealt with as a matter of law.

Plaintiff, American Hospital Association (hereinafter AHA), seeks review pursuant to the Administrative Procedure Act, 5 U.S.C. § 706, of various regulations promulgated under the authority of Titles VI (the "Hill-Burton Act") and XVI of the Public Health Service Act, 42 U.S.C. § 291 *et seq.* and 42 U.S.C. § 300q *et seq.* (1976 and 1980 Supp.) respectively. The regulations are codified at 42 C.F.R. §§ 124.501 *et seq.* and 124.601 *et seq.* No challenge has been made to the procedure by which the regulations were issued. Rather, plaintiff challenges these regulations on substantive grounds contending that they: 1) retroactively impair contractual rights and thus violate the fifth amendment due process provision of the Constitution and 2) are beyond the scope of the authorizing statute.

The regulations define the manner in which health care providers must comply with two assurances they gave in return for receipt of federal construction funds under the Hill-Burton Act. These assurances required providers to "make available a reasonable volume of services to persons unable to pay" (the

charity care assurance) and to make their facilities "available to all persons" residing in their service area (the community service assurance.) 42 U.S.C. §§ 291c(d), 300s-1(b)(1)(k).

Formerly, compliance with the charity care assurance was brought about by means of an "open-door" policy which required providers to certify that no person would be denied medical care because of inability to pay. 42 C.F.R. 42-111(d)(2). The new regulations eliminate this open-door policy and set strict compliance standards at 3% of the facilities' operating costs or 10% of federal assistance received (adjusted to account for inflation) whichever is less. 42 C.F.R. § 124.503(a). Deficits and excesses in compliance in a given year are carried over to subsequent years as an adjustment to that year's compliance requirement. 42 C.F.R. § 124.503(b), (c) and (d). In the case of a deficit an "affirmative action" program is required. 42 C.F.R. § 124.504. Sections 124.502 and 124.509 provide for methods to determine what qualifies as charity care. The compliance requirements apply to recipients of Title VI loans until the loan is repaid. 42 C.F.R. § 124.501(b).

The community service assurance regulations prohibit exclusion of persons in the provider's territorial area on grounds other than need for the service or availability of the service in that facility. 42 C.F.R. § 124.603(a). Section 124.603(a) also allows denial of non-emergency services to those unable to pay for them unless such person qualifies for charity care. Section 124.603(c) requires providers to make arrangements to provide access to Medicare and Medicaid programs. Certain exclusionary policies are prohibited by § 124.603(d).

Regulations were also promulgated for both assurances regarding notice to patients (124.505, 124.603), investigation and enforcement (124.511, 124.606) and reporting and records (124.510, 124.605).

I.

The regulations in question have been promulgated pursuant to two statutes. the original authorizing statute is the Hill-Burton Act. The wording of the statute is broad.[1] It encompasses both the power to promulgate initial regulations[2] and to modify regulations related to compliance with assurances given as a condition of funding under the statute. Plaintiff challenges the constitutionality of the regulations promulgated pursuant to the authorizing statute, charging that they retroactively impair contractual rights in violation of the due process component of the fifth amendment. It is this court's conclusion that plaintiff's argument is without merit.

Plaintiff contends that it has been deprived of due process on two overlapping grounds: 1) that the regulations allegedly alter and impair the health care providers' contractual rights

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[1] The full text of the relevant section is as follows:

The Surgeon General, with the approval of the Federal Hospital Council and the Secretary of Health, Education, and Welfare, shall by general regulations prescribe—

(e) that the State plan shall provide for adequate hospitals, and other facilities for which aid under this part is available, for all persons residing in the State, and adequate hospitals (and such other facilities) to furnish needed services for persons unable to pay therefor. Such regulations may also require that before approval of an application for a project is recommended by a State agency to the Surgeon General for approval under this part, assurance shall be received by the State from the applicant that (1) the facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant; and (2) there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

42 U.S.C. § 291c

[2] *See* discussion, pp. 2c-15c, *supra.*

and 2) that the regulations operate retroactively to alter pre-existing obligations of the providers. Since any alteration of a contractual right against the federal government is necessarily a due process problem[3] and since an existing, executory contract could only be altered by regulations which operate retroactively,[4] plaintiff's arguments are really one—that it has been deprived of property rights without due process. *See Lynch v. U.S.*, 292 U.S. 571 (1934).

Plaintiff's contention, cast in due process language, is that property rights which were acquired by contract with the federal government have been violated by the promulgation of the challenged regulations. Plaintiff asserts that the forms and applicable regulations involved in obtaining Hill-Burton funds constitute a contract. The relevant forms oblige the health care providers to give assurances of charity care and community service and oblige the government to give federal funds in return. Although these forms, in and of themselves, could not constitute a contract because of the indefiniteness of their terms, *AS&W Club of Waukegan v. Drobnick*, 26 Ill. 2d 521, 187 N.E. 2d 247 (1962); *Brewer v. Daubert Chemical Corp.*, 72 Ill. App. 3d 718, 391 N.E. 2d 110 (1979), plaintiff maintains that the regulations in force at the time its members received Hill-Burton funds were incorporated into the alleged agreement, thus making the obligations contained in the application forms definite and enforceable.

In several cases dealing primarily with the issue of implying a private right of action for the indigent third party beneficiaries of the alleged contract, courts have indicated that

[3] The contract clause by its very terms applies only to state action. U.S. Const. Art. I § 10 cl. 1.

[4] The substantive provisions of the regulations apply prospectively only. There is no provision for reassessing compliance in the past under the new standards. The regulations do, however, apply retroactively insofar as they apply to assurances given by hospitals prior to the promulgation of the new regulations.

they accept the existence of a contractual relationship created by the forms; however, none of the holdings have specifically discussed whether the regulations are incorporated into the contract. *Euresti v. Stenner,* 458 F.2d 1115 (10th Cir. 1972); *Corum v. Beth Israel Med. Ctr.,* 359 F. Supp. 909 (S.D. N.Y. 1973); *AHA v. Harris,* 625 F.2d 1328 (7th Cir. 1980) (dissenting opinion). Assuming, for the moment, the validity of these court's findings that a contract exists, it is nevertheless true that since, as is shown below, the Secretary has the power to modify the regulations after the federal funds have been paid, this power was also a part of the terms of any contract that may have arisen. *Cf. Ogden v. Saunders,* 25 U.S. 212 (1827).

The Secretary's power to modify the regulations in question has been demonstrated in several recent cases. In *Austin Welfare Rights Organization v. St. Davis Community Hosp.,* No. A-78-CA-63 (W.D. Texas, March 13, 1980), the court, in construing the grant of regulatory authority[8] to the Secretary contained in the Hill-Burton Act found no retroactivity problem in the promulgation by the Secretary of regulations which modified those in effect when the defendant hospital gave its original charity care and community assurances. The court stated,

> Approval of the hospital's application for Hill-Burton funds was made conditional on an assurance that in the operation of the project there will be compliance with the applicable requirements of the regulations prescribed under § 291c(e) of this title ... 42 U.S.C. § 291 e(b)(3). This statutory provision is sufficient to put the hospital on notice that new or additional regulations to which it would be subject might be promulgated in the future.

Austin at 2-3 (emphasis added).

Similarly in a recent case upholding the regulations challenged here against an essentially identical attack, the court stated,

> Although Congress did not specify in 42 U.S.C. § 291c(e) exactly how the assurances were to be enforced, it can hardly be said that Congress would have authorized the

[8] *See* discussion, pp. 2c-15c, *supra.*

> establishment of such assurances without delegating the power to ensure compliance. Where a delegation of power is made to an administrative agency, the authority to take appropriate action to affectuate that power will be implied. *Morton v. Ruiz*, 415 U.S. 199 (1974); *Northern States Power Co. v. Federal Power Comm.*, 118 F.2d 141 (7th Cir. 1941); *Gallagher's Steak House v. Bowles*, 142 F.2d 531 (2d Cir. 1944).

Wyoming Hospital Association v. Harris, No. C-80-0345B (D. Wyo. Oct. 21, 1981) slip opinion at 8. This implied power includes the power to modify regulations to ensure effective compliance with the assurances given. Congress gave the Secretary broad power originally because it wanted to leave the administration of the assurances fluid and allow the agency to adjust to unforeseen contingencies in effecting compliance. *See Mourning v. Family Publications Service*, 411 U.S. 356 (1973); *Matson Navigation Co. v. Connor*, 258 F. Supp. 144 (N.D. Cal. 1966) *aff'd* 394 F.2d 514, *cert. den.* 393 U.S. 998. "Any new regulations would not alter the nature of the assurances given under the Hill-Burton Act but rather would enforce them as given . . ."[8] *Lugo v. Simon*, 426 F. Supp. 28, 33 (N.D. Ohio 1976).

Even if the power to modify the regulations were not contained in Title VI, Congress has given that power to the Secretary as a result of its passage of Title XVI, 42 U.S.C. 300q *et seq.* This action on the part of Congress invokes no due process problem.

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[8] The regulations are to

> prescribe the general manner in which each entity which . . . has received financial assistance under Part A or B or [Title XVI] subchapter IV of this chapter [Title VI] shall be required to comply with the assurances required to be made at the time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances.

42 U.S.C. § 300s(3). Additionally,

Footnote continued on following page

Constitutional claims similar to those raised by AHA have been rejected by the Supreme Court in at least two cases. One example is *FHA v. The Darlington*, 358 U.S. 84 (1958). Congress, in 1954, had added to the National Housing Act a new section which explicitly prohibited rentals to transients. The section was added subsequent to the time when the renting corporation had received its federal mortgage insurance. The Court upheld the section of the statute, emphasizing that the act did not penalize the corporation for having rented to transients in the past but merely sought to more effectively further the statutory purpose of providing housing for veterans. Quoting *Fleming v. Rhodes*, 331 U.S. 100, 107 (1947), the court stated, "Federal Regulation for future action based upon rights previously acquired by the person regulated is not prohibited by the Constitution ... [T]he fact that its [the statute's] provisions limit or interfere with previously acquired rights does not condemn it. Immunity from federal regulation is not gained through forehanded contracts." 358 U.S. at 91.

Footnote continued from preceding page

> An application for a medical facilities project shall be submitted in such form and manner as the Secretary shall by regulation prescribe and shall, except as provided in paragraph (2), set forth ...
>
> (K) reasonable assurance that at all times after such application is approved (i) the facility or portion thereof to be constructed, modernized, or converted will be made available to all persons residing or employed in the area served by the facility, and (ii) there will be made available in the facility or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the Secretary, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint.

42 U.S.C. § 300s-1(b)(1)

Similarly, in *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1 (1975), the Court again upheld federal legislation that upset the contractual rights of the parties challenging the legislation. The challenged statute imposed on employers the obligation to pay disability and death benefits for Black Lung disease for current employees and for employees who had ceased employment prior to passage of the act. The Court found that the legislation was a rational means to a valid legislative end and stated that "... our cases are clear that legislation readjusting rights and burdens is not unlawful solely because it upsets otherwise settled expectations [citations omitted]." 428 U.S. at 16.

Although *Turner Elkhorn* and *The Darlington* deal with statutes rather than regulations, the same principles should apply to regulations issued pursuant to statutory authority. *Thorpe v. Housing Authority*, 393 U.S. 268, 280 fn. 35 (1968). There is no significant difference between Congress itself making retroactive adjustments, as in the above-cited cases, and Congress authorizing the Secretary to make the adjustments, as in this case. So long as the means employed are a rational means to ensure a valid legislative end the regulations will be upheld despite any unsettling of the parties' expectations.

Several lower court cases presenting an analagous problem involved the retroactive application of a regulation which recaptured reimbursed depreciation if a Medicare health care provider ceased or decreased services. *See Summit Nursing Home, Inc., v. U.S.*, 572 F.2d 737 (Ct. Clms. 1978); *Springdale Convalescent Ctr. v. Matthews*, 545 F.2d 943 (5th Cir. 1977); *Cf. Daughters of Miriam Ctr. for the Aged v. Matthews*, 590 F.2d 1250 (3d Cir. 1978). Both *Summitt* and *Springdale* upheld the retroactive application of the regulation against a due process argument such as AHA makes in the instant case. In *Summitt*, the Court stated that the providers knew that they would be subject to future regulation by the Secretary since the Secretary had the right to issue regulations to cure the defects

arising from prior administration of the program. The *Daughters of Miriam* court upheld the retroactive application to providers who had been terminated rather than been discontinued.[7]

The regulations in question are a rational means to a valid legislative goal—providing health care facilities and services to those who cannot afford them. As stated by the Supreme Court in *The Darlington*, "[t]hose who do business in the regulated field cannot object if the legislative scheme is buttressed by subsequent amendments to achieve the legislative end." 358 U.S. at 91.

II.

In addition to its due process challenge, plaintiff argues that the regulations are invalid because they are not within the scope of statutory authority under the Hill-Burton Act. The statute is framed in general terms and obviously contemplates a significant interpretive role on the part of the Secretary.[8] It states broadly that assurances may be required. The only limitations on the scope of the assurances are: 1) that the persons to whom services are available must reside "in the territorial area of the applicant," 2) that the amount of services must be a "reasonable volume" and 3) that the foregoing assurances apply to "the facility or portion thereof to be constructed or modernized." The statute also provides for an exception to the giving of the reasonable volume assurance where it is financially unfeasible for the health care provider to do so. Additionally, Congress has expressly required as a separate prerequisite to financial assistance, "an assurance that in the operation of the project there will be compliance with the applicable requirements of the regulations prescribed under § 291c(e) of this title . . ." 42 U.S.C. § 291e(b)(3).

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[7] The court refused to uphold the retroactive application to discontinued providers since the regulation in question suffered from procedural infirmities in its issuance, 590 F.2d at 1255, a problem not encountered in the case at bar.

[8] *See* full text of relevant section, n.6, p. 6c, *infra*.

Where Congress has used such broad language, courts have rightfully found that the legislature has contemplated that regulations will be issued to give the assurances meaningful content. *See Citizens to Save Spencer City v. EPA*, 600 F.2d 844 (D.C. Cir. 1979) and cases cited therein at 874. The interpretation required for the giving of such content is the province of the Secretary in charge of the administration of the statute, and the Secretary's interpretation is entitled to great weight. *Udall v. Tallman*, 380 U.S. 1, 16 (1964); *Unemployment Commission v. Aragon*, 329 U.S. 143, 153 (1946). This deference is especially legitimate where, as here, Congress has re-enacted the underlying statute after the agency has issued regulations construing that statute. When Congress acts in this manner without altering the administrative construction, the re-enactment constitutes an implied approval of the agency's actions. *See Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 380-81 (1969) and cases cited therein at n.10. Further, Congress implicitly affirmed the agency action when it passed the Public Health Service Act of 1974 which expressly required the Secretary to issue such regulations.

It is argued that the statute merely authorizes the Secretary to issue regulations requiring the giving of the assurances at the time of funding and that Congress did not intend that these assurances guarantee indigents any type of health care. This argument is without merit. There is no basis for the proposition that Congress intended that health care providers be left with the discretion to determine what constitutes compliance with these assurances. In fact, it is reasonable to assume that Congress contemplated leaving this determination to the expertise of the agency charged with enforcement and expected regulations to be issued which would give substance to otherwise hollow assurances. *Cf. Udall v. Tallman*, 380 U.S. 1, 16-18 (1964); *Unemployment Commission v. Aragon*, 329 U.S. 143, 153-4 (1946).

Case law construing the statute supports a finding that the regulations are within the scope of the statutory grant. In several cases dealing with challenges to regulations promulgated under § 291c(e) which imposed *maximum* time and amount limits on compliance with the assurances given by health care providers, courts have found that the language of the statutory section gave the Secretary authority to issue regulations setting forth standards for compliance with the Hill-Burton assurances. *Cook v. Ochsner Foundation Hospital*, 559 F.2d 968 (5th Cir. 1977); *Lugo v. Simon*, 426 F. Supp. 28 (N.D. Ohio 1976); *Corum v. Beth Israel Medical Center*, 373 F. Supp. 550 (S.D. N.Y. 1974). Ironically, it is the same class of parties that contended in those cases that the statute authorized the Secretary to set a maximum compliance standard who now argue that the same statute does not give the Secretary authority to set a minimum compliance standard.

Further support for this court's holding is found in the statute's legislative history. A clear purpose of the Hill-Burton Act was to provide care for the indigent. As one supporter, Senator Ellender, stated,

> If people in all localities were able to pay for hospitalization there would be no need for this bill. It seems to me that our primary purpose should be to devise means to take care of those who cannot take care of themselves. My reason for supporting a bill providing for Federal aid to build hospitals is to make it easy for the community in which a hospital is built to give aid to the indigent.

Hearings before the Committee on Education and Labor on S. 191, U.S. Senate, 79th Congress, 1st Session, March 12, 1945 at 190-191. *See also Cook v. Ochsner Foundation Hospital*, 559 F.2d 968 (5th Cir. 1977); *Euresti v. Stenner*, 458 F.2d 1115 (10th Cir. 1972); *Wyoming Hospital Association v. Harris*, No. C-80-1345B (D. Wyo. Oct. 21, 1981); *Corum v. Beth Israel Medical Ctr.*, 359 F. Supp. 909 (S.D. N.Y. 1973); *Cook v. Ochsner Foundation Hospital*, 319 F. Supp. 603, 606 (E.D. La. 1970).

It is true that, as plaintiff contends, a review of the legislative history indicates that the primary purpose of the Hill-Burton Act was provision of facilities through federal funding. *American Hospital Association v. Harris*, 625 F.2d 1328 (7th Cir. 1980) (dissenting opinion). However, this does not negate the fact that both the express provision for assurances of care for the indigent in the Act and the legislative history leading to the inclusion of those assurances undeniably demonstrate another significant purpose of the Act—that the health care providers benefitting from this federal funding must in return provide care to the real beneficiaries of the entire program, namely those unable to pay for health care themselves. *See Euresti v. Stenner*, 458 F.2d 1115, 1118 (10th Cir. 1972); *Cook v. Ochsner Foundation Hospital*, 319 F.Supp. 603 (E.D. La. 1970).

Plaintiff's argument that the regulations must be rejected because they are allegedly in violation of § 291m of the Hill-Burton Act must fail. The section states:

> Except as otherwise specifically provided, nothing in this subchapter shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility with respect to which any funds have been or may be expended under this subchapter.

Plaintiff contends that the regulations covering the admission procedures of the hospital, along with other regulations, intrude into the financial, administrative and medical operations of the hospital.

This argument ignores the first clause of the section which expressly states that it is subject to exceptions "as otherwise specifically provided." This is such a case. Sections 291c(e) and 291e(b)(3) provide that assurances can be required and that the Secretary has authority to issue regulations defining compliance with these assurances. It is a cardinal rule of

statutory construction that the provisions of a statute are to be read as a whole. *Philbrook v. Glodgett,* 421 U.S. 707 (1975); *Kokoszka v. Belford,* 417 U.S. 642 (1974), *reh. den.* 419 U.S. 886. Further, as previously stated, the interpretation given the statute by the administrative agency is due great deference. Therefore, since § 291c(e) provides an exception as authorized by § 291m and since the Secretary has interpreted it as doing so, plaintiff's argument is rejected.

Plaintiff's final attack charges that even if the specific regulations are found to be within the scope of the statute, they must nevertheless be found to be unreasonable.

Regulations, even if found, as in this case, to have been promulgated with regard to a subject matter within the scope of the Secretary's authority may be struck down under 5 U.S.C. § 706(a)(A) if they are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." "To make this finding the court must consider whether the decision is based on a consideration of the relevant factors and whether there has been a clear error in judgment. . . . Although this inquiry into the facts is to be searching and careful, the ultimate standard of review is a narrow one." *Citizens to Preserve Overton Park v. Volpe,* 401 U.S. 402, 416 (1971). Where, as here, there is no challenge to the administrative proceeding or the hearing record and the regulations are challenged on a substantive level the court is limited to review of the record before the agency. *Citizens to Preserve Overton Park v. Volpe,* 401 U.S. 402 (1971); *National Broadcasting Co. v. U.S.,* 319 U.S. 190 (1943).

Much is made by plaintiff of the hardship imposed on its members by the regulations in question. While this court is not unsympathetic to their plight, it cannot substitute its judgment for that of the agency. *Bowman Transportation Inc. v. Arkansas Best Freight System, Inc.,* 419 U.S. 281, 285 (1974); *U.S. v. Alleghency Ludlum Steel Corp.,* 406 U.S. 742, 749 (1972).

It is well established that a regulation will not be found inconsistent with a statute unless

> the variance is so clear that it is manifest that the court has no choice except to hold that the administrator has exceeded his authority and employed means that are not appropriate to the end specified in the act.

Lugo v. Simon, 426 F. Supp. at 34 *quoting Gardner v. U.S.*, 239 F.2d 234, 237 (5th Cir. 1956). A court must uphold agency action which has a rational basis. *Bowman Transportation Inc., supra.* A regulation must be sustained so long as it is reasonably related to the purposes of the enabling legislation. *Mourning v. Family Publication Services, Inc.*, 411 U.S. 356, 369 (1973).

It is clear that the regulations as previously issued failed to exact effective compliance with the Hill-Burton assurances. Numerous actions were brought both in court and before the Department of Health, Education and Welfare (now Health and Human Services), the administrative agency charged with enforcement, to enforce compliance with these assurances. *See e.g. Cook v. Ochsner Foundation Hospital*, 559 F.2d 968 (5th Cir.1977); *Euresti v. Stenner*, 458 F.2d 1115 (10th Cir. 1972); *Perry v. Cape Cod Hosp.*, decision on Admin. Complaint (Suffolk, Mass., March 14, 1979); *In re: St Davids Community Hosp.*, decision on Admin. Complaint, (Austin, Texas, June 2, 1978); *In re: Seminole Mem'l Hosp.*, decision on Admin. Complaint (Sanford, Fla., March 27, 1978).

The regulations in question and the substantial administrative record have been reviewed. There is ample support in that record for the regulations as issued by the Secretary. They are a reasonable means of ensuring compliance with assurances given pursuant to the Hill-Burton Act and, thus, are not arbitrary or capricious.

III.

Since plaintiff has asserted no grounds upon which this court could possibly declare the regulations in question invalid, plaintiff's motion for summary judgment is denied and defendants' cross-motions for summary judgment are granted.

/s/ Nicholas J. Bua
Nicholas J. Bua
Judge, United States District Court

DATED: January 8, 1982

In the

United States Court of Appeals

For the Seventh Circuit

No. 79-2162

AMERICAN HOSPITAL ASSOCIATION,

Plaintiff-Appellant,

v.

PATRICIA R. HARRIS, Secretary of the United States Department of Health, Education, and Welfare, et al.,

Defendants-Appellees,

ILLINOIS MIGRANT COUNCIL, et al.,

Intervening Defendants.

Appeal from the United States District Court for the Northern District of Illinois, Eastern Division.
No. 79-C-2869—Nicholas J. Bua, *Judge.*

ARGUED JANUARY 10, 1980—DECIDED JULY 2, 1980

Before PELL, *Circuit Judge*, PECK, *Senior Circuit Judge*,* and WOOD, *Circuit Judge.*

WOOD, *Circuit Judge.* The sole issue on appeal is whether the district court properly refused to grant a preliminary injunction against the operation of regulations promulgated by the Department of Health, Education and Welfare.

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* Senior Circuit Judge John W. Peck of the United States Court of Appeals for the Sixth Circuit is sitting by designation.

Congress, in 1946, enacted Title VI of the Public Health Service Act, 42 U.S.C. §§ 291 *et seq.* (1976) (the Hill-Burton Act), to assist states in constructing and modernizing public hospitals, and to stimulate development of and research about new medical facilities. *Id.* § 291. Title VI made federal funds available for these purposes. As a condition for receiving federal money, the recipient had to assure that it would provide "a reasonable volume of services to persons unable to pay therefor" (charity care) and that the facility or the portion modernized would "be made available to all persons residing in the territorial area of the applicant. . ." (community service). *Id.* § 291c(e). In 1972, partly in response to suits brought alleging inadequate compliance with the "charity care" and "community service" assurances, HEW promulgated regulations. 42 C.F.R. §§ 53.111 and 53.113 (1978). These regulations defined "reasonable volume" and "persons unable to pay," and established a standard for compliance with the community service requirement.

Funding for Title VI was discontinued in 1974. 43 Fed. Reg. 49,954 (Oct. 25, 1978). In 1975, to provide for new programs of federal loans, loan guarantees, and grants for the improvement of medical facilities, Congress enacted Title XVI to replace the program of assistance under Title VI. 42 U.S.C. §§ 300o *et seq.* (1976). Title XVI continued to require the same two basic assurances from grant and loan recipients that were contained in Title VI, namely, the charity care and community service obligations. *Id.* § 300o-3(b)(1)(J).

In 1979, HEW promulgated new regulations. 42 C.F.R. § 124, Subparts F and G. The new regulations, promulgated pursuant to explicit authority to issue regulations contained in Titles VI and XVI, purport to improve the effectiveness of the charity care and community service assurances contained in the statutory sections. The regulations, which became effective September 1, 1979, apply to hospitals which have already received federal assistance and have already made assurances, and expand the nature and scope of these hospitals' obligations for the future. Among other

changes, the new regulations increase the length of time of the obligation to provide uncompensated services, provide for uniform patient eligibility requirements based only on income, make it more difficult to comply with the charity care assurance by eliminating the "open door" provision of the old regulations,[1] require that a failure to comply with the charity care assurance in one year will result in the amount of the deficit being added to the compliance level for future years, and expand the community service obligation by specifying that a recipient of federal funds may not deny admission on any grounds unrelated to the need for hospital services.

The plaintiff, the American Hospital Association (AHA), acting on behalf of its member organizations, brought suit in the district court seeking to have the new regulations preliminarily enjoined. In an order dated October 1, 1979 Judge Bua refused to grant a preliminary injunction finding that the AHA had not shown that its member organizations would suffer irreparable harm, that the AHA had not demonstrated a reasonable likelihood of success on the merits, and that the balance of hardships favored the denial of a preliminary injunction. The AHA appealed that decision to this court. We affirm.

The purpose of a preliminary injunction is to preserve the status quo pending a final hearing on the merits. *Morgan v. Fletcher*, 518 F.2d 236, 239 (5th Cir. 1975). The decision to grant or deny injunctive relief is addressed to the sound discretion of the trial court and appellate review of that decision is very limited. *Kolz v. Board of Education of City of Chicago*, 576 F.2d 747, 748 (7th Cir. 1978) (per curiam); *Banks v. Trainor*, 525 F.2d 837, 841 (7th Cir. 1975), *cert. denied*, 424 U.S. 978 (1976); *American Medical Association v. Weinberger*, 522 F.2d 921, 924 (7th Cir. 1975). The discretion of the dis-

[1] Under the old regulations a recipient of federal funds was in compliance with the charity care assurance if it certified that it would not exclude any person from admission because the person was unable to pay. 42 C.F.R. § 53.111(d)(2). The new regulations eliminate this "open door" option.

trict court is not totally unrestrained, however, but must be exercised in the context of balancing the four prerequisites for injunctive relief: "a reasonable probability of success on the merits, irreparable injury, the lack of serious adverse effects on others, and sufficient public interest." *Kolz*, 576 F.2d at 749. While no one factor is determinative, "if a court finds that under applicable law there is no probability of success on the merits and no irreparable injury, it is unnecessary for the court to consider the other factors." *Id.*

The AHA asserts that the trial court erred in finding that AHA would not suffer irreparable harm pending a full hearing on the merits. Specifically, the AHA argues that the charity care and community service provisions of the new regulations may force member hospitals to rearrange its medical staffs and organizational policies, will cause the abandonment of hospitals' sound fiscal policies, will result in a loss of revenues to the hospitals, will limit allowable credit, and that the administrative costs of compliance with the regulations will be high.

We find that the district court did not abuse its discretion in deciding that the AHA's member organizations would not suffer irreparable harm pending a final hearing on the merits. We note first that to constitute irreparable harm "the threatened injury must be, in some way, 'peculiar.'" *A. O. Smith Corp. v. FTC*, 530 F.2d 515, 527 (3d Cir. 1976). "Mere injuries, however substantial, in terms of money, time and energy necessarily expended in the absence of a stay, are not enough." *Morgan v. Fletcher*, 518 F.2d at 240 (quoting *Virginia Petroleum Jobbers Association v. Federal Power Commission*, 259 F.2d 921, 925 (D.C. Cir. 1958)). Only harm that the district court cannot remedy following a final determination on the merits may constitute irreparable harm. *A. O. Smith*, 530 F.2d at 527. In addition, injury resulting from attempted compliance with government regulation ordinarily is not irreparable harm. *Id.*

Here, as the district court noted, many of the complained of costs should already have been incurred prior to the hearing on the preliminary injunction if the

member hospitals hoped to be in compliance with the regulations by September 1, 1979, the day the regulations became effective. In addition, the district court properly concluded that some of the complained of harm to the AHA could be remedied by the court should the AHA succeed at the final hearing on the merits. We further believe that the district court acted within its discretion in concluding that any remaining injury was unduly speculative or too insubstantial to constitute threatened irreparable harm. The district court properly considered the claimed injuries to the AHA and its member hospitals and did not abuse its discretion by finding that the claimed injuries did not amount to a showing of irreparable harm.

The district court also concluded that the AHA had not exhibited a reasonable likelihood of success on the merits. The required showing of probability of success on the merits "varies with the quality and quantum of harm that [the moving party] will suffer from the denial of an injunction. [W]here it appears that a lack of showing of irreparable harm * * * exists . . . the party seeking a preliminary injunction has a burden of convincing with a reasonable certainty that it must succeed at [the] final hearing.'" *District 50, United Mine Workers of America v. International Union, United Mine Workers of America*, 412 F.2d 165, 168 (D.C. Cir. 1969) (quoting *Dino de Laurentiis Cinematografica v. D-150, Inc.*, 366 F.2d 373, 375 (2d Cir. 1966)).

The AHA claims that the new regulations exceed the statutory authority delegated to HEW, are in certain respects inconsistent with expressed congressional intent, unlawfully alter the contractual rights of Hill-Burton hospitals, and conflict with the Medicare conditions of participation. We have reviewed the arguments of the parties and have decided that the district court was within its discretion in concluding that the AHA had not established with reasonable certainty that it would eventually prevail.

The record, following only a hearing on the preliminary injunction, is abbreviated. Both parties presented extensive argument on the statutory language

and legislative history. The district court considered the appropriate legal issues. While we do not intend to prejudge the merits of the AHA's case, our review of the record, as presented so far, does not establish that the district court abused its discretion in finding that the AHA had not shown, with a reasonable certainty, that it would prevail on the merits.[2]

Accordingly, we affirm the denial of the preliminary injunction.[3]

AFFIRMED.

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[2] The district court also ruled that to grant a preliminary injunction would impose on poor individuals needing hospital care "a hardship that is far greater than any the AHA's member organizations will have to endure." Because we have concluded that the district court did not abuse its discretion in finding that the AHA member organizations had not established a threat of irreparable harm and had not shown a probability of success on the merits, we need not consider the district court's conclusion on the balance of hardships.

[3] In dissent Judge Pell provides an exhaustive analysis of plaintiff's likelihood of success upon the merits, one of the four prerequisites to be met by the plaintiff to justify a preliminary injunction. Even though on the abbreviated record before us we are not prepared to adopt his views, Judge Pell's dissent may serve as a helpful brief for consideration of the trial judge upon the full trial of the case. For our present purposes, we note on the other hand that one of the other essential prerequisites, irreparable harm, is lightly treated in the dissent. Remembering that our standard of review is one of "abuse of discretion," we decline to set aside the findings of the trial judge by speculating on some possible harm to plaintiff which a damage award would not cure in the event plaintiff ultimately prevails.

PELL, *Circuit Judge*, concurring in part and dissenting in part.

Although the issue presented by this appeal might be thought to be a narrow one, I do not agree that the district court properly exercised its discretion in denying preliminary injunctive relief to the AHA with respect to certain of the challenged regulations. The standard for such relief is not disputed. A party seeking preliminary injunctive relief must carry the burden of persuasion on the following four prerequisites: (1) there must be a reasonable likelihood that the plaintiff will succeed on the merits; (2) the plaintiff must have no adequate remedy at law and must show that it will be irreparably harmed if the injunction is not issued; (3) the threatened harm to the plaintiff must outweigh the probable harm the injunction will inflict on the defendant; and (4) the granting of the injunction must not disserve the public interest. *Fox Valley Harvestore, Inc. v. A.O. Smith Harvestore Products, Inc.*, 545 F.2d 1096, 1097 (7th Cir. 1976).

While the majority opinion acknowledges that the purpose of a preliminary injunction is to maintain the status quo pending the outcome of the litigation, it appears not to acknowledge the correlative principle that a stronger case for preliminary relief is presented where, as here, that is the precise objective that the injunction will further. *See, e.g., Banks v. Trainor*, 525 F.2d 837, 841 (7th Cir. 1975), *cert. denied*, 424 U.S. 978 (1976); *District 50, United Mine Workers of America v. International Union, United Mine Workers of America*, 412 F.2d 165, 168 (D.C. Cir. 1969); *cf. South East Chicago Commission v. Department of Housing and Urban Development*, 488 F.2d 1119, 1127 (7th Cir. 1973) (purpose of preliminary injunction is to maintain the status quo pending final judgment; party who fails to seek preliminary relief may therefore not complain of activities of opposing party after suit filed).

Because the status quo is considered to be the last *uncontested* status which preceded the lawsuit, *Westinghouse Electric Corp. v. Free Sewing Machine Co.*, 256 F.2d 806, 808 (7th Cir. 1958), that status for the pur-

poses of this litigation is the regulatory situation which existed prior to the effective date of the challenged regulations. Bearing these principles in mind, the question before this court, then, is whether the AHA carried its burden with respect to each of the standard requirements for the requested relief.

I.

Likelihood of Success on the Merits

An analysis of whether AHA is likely to prevail on the merits in this action[1] would seem necessarily to involve first an examination of the nature and extent of the obligations assumed by the facilities in question at the time of their decision to obtain Hill-Burton funding, secondly, a determination of the scope of the Secretary's power to define that obligation in light of the relevant statutory provisions, and, finally, a determination as to whether the 1979 regulations challenged here are within the ambit of that authority.

A. *Evolution of the Assurances*

The Hospital Survey and Construction Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (current version at 42 U.S.C. §§ 291-291l (1976 & Supp. II 1978)), commonly known as the Hill-Burton Act, was enacted as a result of a message sent to Congress by President Truman on November 19, 1945, in which the President urged the passage of legislation which would ensure adequate health care for all. *See* President Truman's Message to Congress on Health Legislation, [1945] U.S. Code Cong.

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[1] It should be noted that the test in this circuit for preliminary relief is *likelihood* of success on the merits, not a "reasonable certainty" of success as both the majority and the district court opinion seem to indicate. *Compare Fox Valley Harvestore, Inc. v. A. O. Smith Harvestore Products, Inc.*, 545 F.2d 1096, 1097 (7th Cir. 1976) *with District 50, United Mine Workers of America v. International Union, United Mine Workers of America*, 412 F.2d 165, 168 (D.C. Cir. 1969).

& Ad. News 1143.[2] The message detailed five programs thought by President Truman to be necessary to achieve this goal: (1) construction of hospitals and related facilities; (2) expansion of public health, maternal, and child health services; (3) programs which would encourage medical education and research; (4) prepayment of medical costs in order to assure access to necessary medical and hospital services; and (5) protection against wage loss resulting from sickness or disability.

An examination of the express language of the original statute demonstrates that the Hill-Burton Act was addressed primarily to the *first* of these five factors, i.e., to the construction of facilities rather than the provision of services.[3] The purpose of the Act, as set forth expressly in the statute was merely

> . . . to assist the several States—
>
> (a) to inventory their existing hospitals . . . to survey the need for construction of hospitals, and to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people; and

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[2] The President's message was no doubt a response to the serious economic and geographic barriers to health services that had been highlighted during the depression and particularly during World War II when medical examinations conducted by the Selective Service System revealed alarmingly high disability percentages among inductees. *See* Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 Yale L.J. 243, 264-65 (1978) (hereafter Rosenblatt).

[3] It was not until 1965 with the passage of Medicare and Medicaid that legislation directed at providing low or no cost health care to those unable otherwise to afford it was enacted. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 1801-1875, 79 Stat. 299 (1965) (Medicare) (current version as amended at 42 U.S.C. §§ 1395-1395rr (1976 & Supp. II 1978)) and *id.* at §§ 1901-1906, 79 Stat. 343 (Medicaid) (current version as amended at 42 U.S.C. §§ 1396-1396k (1976 & Supp. II 1978)).

(b) to construct public and other nonprofit hospitals in accordance with such programs.

Pub. L. No. 79-725, § 601, 60 Stat. 1040 (1946).[4] In order to effectuate the stated goal, the Act provided for shared administration between federal and state agencies. The Surgeon General was empowered to issue regulations[5] specifying the terms under which state agencies could assume administrative responsibility for Hill-Burton

[4] Section 601 was amended in 1949, Act of Oct. 25, 1949, ch. 722, § 6, 63 Stat. 900-01 (1949), and again in 1954, Act of July 12, 1954, ch. 471, § 4(a), 68 Stat. 464 (1954). It was not until an amendment in 1964, however, that the phrase "physical facilities" was dropped from subsection (a) of the statutory declaration of purpose. Even the 1964 amendment, it should be noted, did not indicate a change in emphasis from the construction of facilities to the provision of services. Rather, it merely evidenced a new emphasis in the program on modernization of existing structures as well as the construction of new ones. The 1964 declaration of purpose, which is still in effect, provides:

> The purpose of this subchapter is—
>
> (a) to assist the several States in the carrying out of their programs for the construction and modernization of such public or other nonprofit community hospitals and other medical facilities as may be necessary, in conjunction with existing facilities, to furnish adequate hospital, clinic, or similar services to all their people;
>
> (b) to stimulate the development of new or improved types of physical facilities for medical, diagnostic, preventive, treatment, or rehabilitative services; and
>
> (c) to promote research, experiments, and demonstrations relating to the effective development and utilization of hospital, clinic, or similar services, facilities, and resources, and to promote the coordination of such research, experiments, and demonstrations and the useful application of their results.

42 U.S.C. § 291 (1976).

[5] Both the original Act and the 1964 general amendments, Pub. L. No. 88-443, 78 Stat. 447 (1964), assigned federal administrative responsibility to the Surgeon General of the United States Public Health Service. The functions of the Surgeon General were transferred to the Secretary of HEW by § 1(a) Reorganization Plan No. 3 of 1966. For the complete text of the plan see the notes following 42 U.S.C. § 202 (1976).

funds, and the state agencies in turn were given authority to recommend approval or rejection of grant applications and to supervise participating facilities.

Additionally, the Surgeon General was authorized to issue regulations requiring that certain assurances, known as the uncompensated care and community service assurances, be given by the applicant to the state before the state recommended approval of the application. With respect to this latter provision, because the Surgeon General did in fact promulgate such regulations, and because it is this statutory provision which furnished the original basis for the regulations challenged here today, background discussion is necessary of how that authority to require assurances came to be included in the Act.

The draft bill which ultimately became the Hill-Burton Act contained no references to any community service or uncompensated care assurances which would be required of recipient facilities. *See* Proposed Amendments to the Public Health Services Act: Hearings on S. 191 Before the Senate Committee on Education and Labor, 79th Cong., 1st Sess. 1-6 (1945) (hereinafter 1945 Hearings).[6] Rather, the bill was aimed purely at subsidizing construction of hospitals and health care facilities where needed. In his opening statement at the 1945 Hearings, Senator Lister Hill introduced the measure as a "first step" toward ensuring adequate health care for all through the mechanism of facilitating necessary construction. 1945 Hearings, *supra*, at 7. The "first step" language is consistent with the view that the Act was intended to be only a partial response to the needs detailed in President Truman's message. Similarly, Senator Pepper stated on numerous occasions during the hearings that the purpose of the bill was to serve as the *first step* of a medical program through the provision of facilities. The Senator's initial "first step" reference took place during the statement of Dr. Smelzer, then President of the AHA, and is particularly significant because it was expressed during

[6] For an excellent review of the legislative history of Act, *see* Note, *Due Process for Hill-Burton Assisted Facilities*, 32 Vand. L. Rev. 1469 (1979).

colloquy over whether the bill should serve as a vehicle for the provision of services:

> The Chairman (Senator Murray): Could the administrator of this bill compel a State to see to it that all the people are going to get care in these hospitals, that they are going to be aided through the system?
>
> Dr. Smelzer: I think if this bill will provide the hospitals, will develop *programs for the construction of such public and nonprofit hospitals*, people who get into them will be taken care of at the local level.
>
> . . . .
>
> Senator Pepper: You are leaving it to us to find, if we can, some proper way to aid the people, all the people in getting access to these hospital facilities and services, and this is considered as a first step and merely as a part of a whole program. *This bill, mainly, is to provide facilities.*
>
> Dr. Smelzer: That is correct.

1945 Hearings, *supra*, at 30-31 (emphasis supplied). After the conclusion of Dr. Smelzer's testimony, the Senator again reiterated that while any comprehensive medical program would contain two parts, provision of facilities and provision of services to those who needed them, the bill under consideration dealt only with the first. *Id.* at 64-65.

The intervenors, however, dispute the "facility emphasis" reading of the legislative history and instead rely on a statement by Senator Ellender, quoted out of context, as support for the proposition that the principal focus of the Act was aimed at shifting the responsibility for the health care of indigents onto grant recipients. Senator Ellender's statement was made in response to the remarks of other senators during the testimony of Dr. Frederick D. Mott, Chief Medical officer of the Farm Security Administration.

Dr. Mott, who is also quoted by the intervenors, suggested that the bill should contain some safeguards to ensure that recipients of federal funds carry out the

legislative purpose of providing facilities for furnishing adequate medical services. Otherwise, he feared that the subsidized structures would be "diverted to some restricted use not contemplated at the time of approval of the project." *Id.* at 188-190. In response to this, Senator Taft suggested that perhaps facilities accepting aid should have an obligation to provide care for a specified number of indigent patients. Contrary to the interpretation advanced by the intervenors, *both Dr. Mott and Senator Pepper then expressed the view that such a requirement might overburden hospitals.* In view of this response from Dr. Mott, it is more likely that his suggestion regarding "safeguards" was addressed to a fear that federal funds might be used for construction of hospitals with racially discriminatory admissions practices, a concern no doubt grounded in the fact that segregation was, in 1945, a de jure practice in some regions of the country and a de facto state of affairs generally. Senator Taft then replied, "I do not know whether it ought to be a requirement, although I expect you might modify that through health insurance, or something of that kind." *Id.* at 190. Senator Pepper again reiterated his view that the burden of caring for indigents should rest upon the public and not upon a particular facility. Senator Ellender concurred, and reasoned, in the statement relied on by intervenors, that if federal funds were available to subsidize construction, it would be easier for the local community involved to provide funding for indigent care:

> If people in all localities were able to pay for hospitalization, there would be no need for this bill. It seems to me that our primary purpose should be to devise means to take care of those who cannot take care of themselves. *My reason for supporting a bill providing for Federal aid to build hospitals is to make it easy for the community in which a hospital may be built to give aid to the indigent.* Unless some method is provided whereby the indigents and those unable to pay for hospitalization can be taken care of, I would not be much interested in providing Federal funds to build hospitals in various parts of our nation.

Id. at 191 (emphasis supplied). Senator Pepper agreed, "That is the next problem we have got to devote ourselves to—is how to make these facilities available to the people." *Id.* Senator Taft concluded the discussion by observing, "my interest in [this bill] is like in a public works bill, just to provide construction. But beyond that, these facilities must be made available to the people." *Id.*

Clearly no fair reading of the above exchange supports the position advanced by the intervenors that Congress intended for the Hill-Burton Act, standing alone, to impose broad indigent care obligations on participating hospitals. Neither does the language of the assurances themselves support such a proposition.

The assurances were added after the above hearings during executive sessions of a Senate subcommittee studying the legislation.[7].

While some conjecture as to the Congressional purpose often is necessary, the clear language of the statute in the case of the first assurance, now referred to as the

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[7] No further mention of the assurances occurs in either the 1945 Hearings, the Senate Report, *see* S. Rep. No. 674, 79th Cong., 1st Sess. (1945), or the Report of the House Committee on Interstate and Foreign Commerce. The assurances, as they appeared in the original Act, are as follows:

> Such regulations [of the Surgeon General] may require that before approval of any application for a hospital is recommended by a State agency, assurance shall be received by the State from the applicant that
>
> (1) such hospital or addition to a hospital shall be made available to all persons residing in the territorial area of the applicant, without discrimination on account of race, creed, or color, but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group; and (2) there will be made available in each such hospital or addition to a hospital a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial standpoint.

Pub. L. No. 79-725, § 622(f), 60 Stat. 1040 (1946).

community service assurance, seems to me to lead to the inescapable conclusion that it was included in response to the concern expressed by Dr. Mott during the Senate Hearings that recipients might divert the funds to "restricted," *i.e.*, racially discriminatory, uses, rather than using the funds to construct facilities serving "all persons residing in the territorial area" as the statute required. The provision, with its "without discrimination on account of race, creed, or color" language, was, in short, simply a typical civil rights provision.[8] Consistently, the sole original regulation promulgated in 1947 by the Surgeon General pursuant to this assurance was simply a restatement of the statutory language. *See* 42 C.F.R. § 53.111-.112 (1960).

The second provision, which required a participating hospital to assure that a reasonable volume of services would be made available to persons unable to pay, with the exception of situations where such a requirement was not financially feasible, likewise appears to be of a straightforward nature. While the Act was addressed primarily to the problem of providing adequate numbers of hospitals, several senators, as discussed previously, were concerned that facilities constructed with federal funds be made available to the people to the maximum extent practicable. This concern was no doubt heightened by the pragmatic possibility that "phase two" legislation directed toward providing health services to

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[8] The fact that the provision as enacted in 1946 contained a "separate but equal" clause is supportive of this conclusion. This clause was subsequently held unconstitutional in *Simkins v. Moses H. Cone Memorial Hospital*, 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964). When Congress thereafter eliminated the clause, it also eliminated the words "without discrimination on account of race, creed, or color." Pub. L. No. 88-443, § 703(e), and instead authorized the administering agency to require an assurance that the assisted facility would be made "available to all persons residing in the territorial area of the applicant." *Id.*, (codified at 42 U.S.C. § 291c(e)). As one commentator has concluded, "The legislative intent behind this provision appeared to be acquiescence in the *Simkins* prohibition of racial discrimination without explicit statutory language reaching that result." Rosenblatt, *supra* note 2 at 266 n.80.

those in need might be somewhat more difficult to pass.[9] At the same time, however, the unanimous opinion during the Committee hearings was that it would be unduly burdensome to require a specified amount of indigent care, and a further concern had been expressed that some hospitals, even with construction subsidies, might have insufficient funds for operations costs. *See* 1945 Hearings, *supra*, at 177-191.[10] Finally, the Committee was fully aware that many, if not most, hospitals already had voluntarily assumed substantial responsibility for charitable care. Senator Taft, for example, had openly pondered the possibility of imposing an absolute requirement for a quota of indigent care, but had simultaneously observed that "I imagine every hospital of a general nature would be lucky if they did not have 20 percent indigent patients." Thus, the most reasonable conclusion that can be drawn about the ultimate inclusion of the assurance is that it represented a limited compromise. Hospitals with the financial capability of providing charity care would be required to do so, and those that found it fiscally impracticable would not. Therefore, while the assurance should be given operative effect, it is simply not a fair reading of either the statute or the legislative history to view the uncompensated care provision as a mandatory social welfare program in and of itself. The statute, it will be recalled, specifically stated that, "an exception shall be made if such a requirement is not feasible from a financial viewpoint."

The 1947 regulations that were promulgated by the Surgeon General under the uncompensated care assurance were, as with the community service assurance, of an unambiguous nature. By way of example, the definition of what would constitute a reasonable volume of uncompensated care was as follows:

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[9] In fact, it took nineteen years to pass the Medicare and Medicaid programs. *See* note 3 *supra*.

[10] The Committee had, in any event, suggested at one point that consideration should be given to subsidizing the operating budgets of hospitals. Senator Murray, the Committee Chairman, had noted that one of the reasons for the hospital shortage was the fact that facilities had experienced a shortage of operating funds. *Id.* at 177-78.

> In determining what constitutes a reasonable volume of free patient care, there shall be considered conditions in the area to be served by the applicant, including the amount of free care that may be available otherwise than through the applicant.

42 C.F.R. § 53.113 (1960). The regulation further made provision for the statutory exception:

> The requirement of assurance from the applicant may be waived if the applicant demonstrates to the satisfaction of the State Agency, subject to subsequent approval by the Surgeon General, that furnishing such free patient care is not feasible financially.

Id. Finally, the regulation specified criteria for determining persons unable to pay,[11] and detailed what sources of community funding could appropriately be utilized to meet the uncompensated care obligation.[12]

Because no new regulations were promulgated until the issuance of new uncompensated care regulations in 1972, 37 Fed. Reg. 14719 (1972),[13] it was the above statutory and regulatory framework which defined, as of the time of contracting the scope of a hospital's Hill-Burton obligation under the terms of its grant or loan agreement insofar as those facilities participating in the program between 1946 and 1972 are concerned. While

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[11] " 'Persons unable to pay therefor' [include] both the legally indigent and persons who are otherwise self-supporting but are unable to pay the full cost of needed hospital care." *Id.*

[12] "Such care may be paid for wholly or partly out of public funds or contributions of individuals and private and charitable organizations such as community chests or may be contributed at the expense of the hospital itself." *Id.*

[13] The regulation was issued in interim form on July 22, 1972, by HEW, with a commitment in the preface to reconsider the matter within 90 days due to certain procedural questions which had been raised in the consideration of the regulation. The final regulation, with technical changes, was issued on June 22, 1974, 38 Fed. Reg. 16353 (1973). *See* Rose, *Federal Regulation of Services to the Poor Under the Hill-Burton Act; Realities and Pitfalls*, 70 Nw. U. L. Rev. 168, 175 n.46 (1975).

the record is not sufficiently developed at this stage of the litigation to permit a determination of what percentage of AHA's membership received grants or loans during this time period, it appears that the percentage is a substantial one. This follows from the fact that it is not disputed that significant funding has not been available under Title VI, the original Hill-Burton Act, since 1974.

Beginning in the late 1960's and into the early 1970's, several private plaintiffs and public interest groups filed suits against federally assisted hospitals, alleging refusal by the hospitals to comply with the terms of the Hill-Burton assurances. HEW was frequently joined as a defendant in these actions for its apparently complete failure as of that time to enforce the Act and the 1947 regulations. I do not disapprove in toto the current regulations, *see* discussion *infra*, and it is evident that much of this early litigation was unfortunately necessary in order to force assisted hospitals to provide even token charitable care. Even when the hospital did not claim to be within the statutory exception for financial impracticability, the facts as developed in these early cases indicated that some facilities, deplorably, maintained firm policies of refusing charity care, sometimes with tragic results. *See* Comment, *Provision of Free Medical Services by Hill-Burton Hospitals*, 8 Harv. Civ. R. Civ. L. L. Rev. 351 n.4 (1973) (patients refused admission to Hill-Burton hospital due to inability to pay died thereafter).

In any event, one of the principles which emerged from this early period of litigation was that the transactions between the hospitals and the relevant administrative agencies were of a *conctractual* nature.[14]

[14] A second issue which was addressed in most of these cases was whether a private right of action should be implied under the Act. The vast majority of courts answered in the affirmative. *See Saine v. Hospital Authority of Hall County*, 502 F.2d 1033, 1034-35 (5th Cir. 1974); *Eureste v. Stenner*, 458 F.2d 1115, 1118 (10th Cir. 1972); *Corum v. Beth Israel Medical Center*, 359 F.Supp. 909, 914-15 (S.D.N.Y. 1973) (also holding that corporate plaintiffs, neighborhood organizations alleging injury to their members, have standing to enforce the Act);

(Footnote continued on following page)

For example, in *Euresti v. Stenner*, *supra*, Retired Justice Clark, sitting by designation, wrote for the court:

> The contract between [the hospital] and the State of Colorado explicitly incorporates the federal statutory obligation. In turn, the State's obligation to provide assurances of compliance is the sine qua non for the furnishing of federal funds. Indeed, [the hospital's] obligation is set out specifically in the closing papers signed by the hospital, the State and federal authorities. Nothing could be clearer: In receiving federal funds, [the facility] obligated [itself] to dispense a reasonable amount of free hospital services to those unable to pay.

458 F.2d at 1118-19 (footnote omitted). *Accord Corum v. Beth Israel Medical Center*, 359 F.Supp. 909, 912 (S.D.N.Y. 1973) (giving of uncompensated care assurance created a contractual relation intended to benefit those who could not pay).

Although none of these early cases resulted in a court order against HEW, the joinder of the agency no doubt induced in part the drafting of the 1972 uncompensated care regulations, which attempted to define more specifically what would constitute compliance with that obligation. The level of free service which, under the 1972 regulation, constituted "presumptive compliance" was an amount equivalent to the lesser of three percent of the facility's operating costs, or ten percent of all federal assistance provided to the facility under the Act, excluding that received under supplemental programs. Alternatively, a facility could certify that it would turn away no one who sought free care, a course which became known as the "open door" option. *See* 42 C.F.R. § 53.111(d) (1975). With respect to those facilities not

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[14] *continued*
Organized Migrants in Community Action, Inc. v. James Archer Smith Hospital, 325 F.Supp. 268, 271 (S.D. Fla. 1971); *Cook v. Ochsner Foundation Hospital*, 319 F.Supp. 603, 606 (E.D. La. 1970). *Contra Stanturf v. Sipes*, 224 F.Supp. 883, 890 (W.D. Mo. 1963), *aff'd*, 335 F.2d 224 (8th Cir. 1964), *cert. denied*, 379 U.S. 977 (1965).

electing the open door option, the failure of a facility to attain a compliance level in one year did not result in a deficit being carried over, but rather in a requirement that the facility prepare a statement justifying the failure and describing what steps would be taken to assure compliance in the future. *Id.* at § 53.111(e)(2). A durational limit of twenty years was also established for the uncompensated care commitment.[15]

The community service obligation thereafter also became the subject of regulatory action, this time as a direct result of litigation. In *Cook v. Ochsner Foundation Hospital*, 61 F.R.D. 354 (E.D. La. 1972), the court held that the Secretary had violated his obligation to enforce the Act by not requiring Hill-Burton facilities in New Orleans to participate in the Medicaid program. Noting that Medicaid participants constituted eleven percent of the metropolitan population, the court reasoned that their exclusion from Hill-Burton facilities was a form of "discrimination" in violation of the express terms of the Act and the grant assurances. *Id.* at 356 n.1. Thereafter, HEW amended the community service regulation to provide:

> In order to comply with its community service assurance an applicant must: . . . make arrangements, if eligible to do so, for reimbursement for services with: (A) Those principal State and local governmental third-party payors which provide reimbursement for services that is not less than the actual cost of such services as determined in accordance with accepted cost accounting principles; and (B) Those Federal governmental third-party programs, such as Medicare and Medicaid, to the extent that the applicant is entitled to reimbursement at reasonable cost under a formula established in accordance with applicable Federal law.

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[15] In *Newsome v. Vanderbilt University*, 453 F.Supp. 401, 413 (M.D. Tenn. 1978), the court held that since precise records of opening dates were not kept, the date from which the twenty year period would run was that of the final funds approval.

42 C.F.R. § 53.113(d)(2) (1976). As with the uncompensated care assurance, a twenty year durational limit was established for the community service obligation, but was later struck down in an unreported order in *Cook v. Ochsner Foundation Hospital*, Civil No. 70-1969 (E.D. La., order filed March 13, 1975), and was subsequently removed from the regulation. *See* 42 C.F.R. § 53.113(a) (1978). Finally, although a facility could not, in accordance with the regulation quoted above, refuse admission on the basis that reimbursement would have to be applied for through Medicare or Medicaid, hospitals were permitted under the new community service regulation to refuse admission based on age, medical indigency, or a type or kind of mental disability. *Id.* at § 53.113(d)(ii).[16]

The last regulatory action preceding the regulations at issue here was a modification of the uncompensated care regulations to comport with the judgment in *Corum v. Beth Israel Medical Center*, 373 F.Supp. 550 (S.D.N.Y. 1974) to require a determination of eligibility for uncompensated care prior to the provision of services, except in cases of emergencies. 42 C.F.R. § 53.111(f)(1) (1978). Facilities were further required to place notices in prominent locations throughout the hospital regarding the availability of uncompensated services. *Id.* was § 53.111(i).

As the above discussion, necessarily lengthy, illustrates, the regulatory actions taken prior to the issuance of the 1979 regulations were primarily of a definitional nature and were well within the range permitted by the nature of the original contract between the assisted facilities and the government entities involved. None of the regulations had the effect of adding new obligations, not contemplated at the time of the original agreement to the performance obligations assumed by the hospitals.

It was at this juncture that funding ceased to be available under the original Hill-Burton Act (Title VI),

[16] *But see* discussion *supra* regarding obligations under the uncompensated care assurance.

and the supplemental program embodied in Title XVI was enacted. The AHA has contended, and the parties do not dispute, that Title XVI funds have *never been available* to AHA members.[17] In enacting Title XVI to replace Title VI as a source of funds, Congress specified a more limited statutory purpose, with the emphasis being on modernization rather than new construction, except in areas where there had been "recent rapid population growth." 42 U.S.C. § 300o (1976). During the hearings on Title XVI, some attention was given to the fact that the record of adherence to the uncompensated care and community service assurances had been less than exemplary under Title VI. The Senate Committee Report, for example, observed that implementation of the uncompensated care assurance was in its infancy at the state and local level due to the fact that there were no monitoring programs in existence, and categorized enforcement generally as a "sorry performance." Senate Report 93-1285, 93rd Cong., 2nd Sess., reprinted in [1974] U.S. Code Cong. & Ad. News at 7900. The Congressional response to this state of affairs was to include in Title XVI "various provisions to strengthen efforts to enforce the assurances." *Id.* Among these provisions was 42 U.S.C. § 300p-2(c), transferring enforcement power under both Title XVI and Title VI from the state agencies to HEW, and § 300o-1, which not only authorized but required the Secretary to

> (6) prescribe the general manner in which each entity which receives financial assistance under this subchapter or has received financial assistance under subchapter IV of this chapter [Title VI] shall be required *to comply with the assurances required to be made at the time such assistance was received* and the means by which such entity shall be required to demonstrate compliance with such assurances.

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[17] The only Title XVI appropriations to date have, according to the briefs, been made pursuant to Part D, which provides for project grants to public hospitals for narrowly circumscribed purposes, i.e., eliminating fire and safety hazards, or avoiding non-compliance with licensing or accreditation standards. *See* 42 U.S.C.A. § 300r(a) (Supp. 1978).

> An entity subject to the requirements prescribed pursuant to paragraph (6) respecting compliance with assurances made in connection with receipt of financial assistance shall submit periodically to the Secretary data and information which reasonably support the entity's compliance with such assurances. The Secretary may not waive the requirement of the preceding sentence.

Id. (emphasis supplied). Thus, in Title XVI, Congress clearly manifested an intent that the assurances, *made at the time that federal assistance was received*, should be given effect. Because the AHA's members received funding under Title VI only, the extent of their obligations must therefore be measured in terms of the assurances given at the time each facility entered into its contract with the federal and state governments.

The government and the intervenors, however, dispute the contractual characterization of the existing relation. HEW, for example, asserts that facilities which have already received funds have no contract because the Government's obligations are "fully executed." This in my view amounts to nothing more than an argument that the fact the Government's performance has been completed gives it the right unilaterally to alter the scope of the performance which may be demanded of the other contracting party, a position which represents, to say the least, a novel theory of contract law.[18]

Further, HEW and the intervenors contend that the passage of Title XVI somehow increased the scope of the Secretary's authority to impose more stringent forms of regulation on hospitals assisted under Title VI. While I agree that both the statutory language and the legislative history of Title XVI evidence a desire on the part of Congress that meaningful steps be taken to ensure that *all* facilities comply with the terms of whatever assurances were given at the time of the original grant or loan, I do not agree that the statute should be read to

[18] Putting aside legal terminology, this is commonly referred to as changing the rules in the middle of the game.

authorize an alteration of the original contract terms. To hold otherwise would be inconsistent with the 42 U.S.C.A. § 300o-1(6), quoted above.

Further, to hold that the statute authorizes the Government to enter into a contract and subsequently utilize its sovereign power, in this instance, through the promulgation of regulations, to exact a greater degree of performance from the private party than was contemplated in the original bargain, would violate not only established contract principles, but also the federal constitution. It is therefore a construction which should be avoided.

It is well established that parties contracting with a state are protected by the contract clause, U.S. Const., Art. I, § 10, from state attempts to utilize legislative authority to impair their contractual obligations. *See, e.g., Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 244 (1978) (stating in dictum that legislative modifications of contracts to which the state is a party will be evaluated with particular scrutiny); *United States Trust Co. v. New Jersey*, 431 U.S. 1, 24 (1977) (holding unconstitutional statute which authorized one party to assume greater risks, thereby permitting a diminution of pledged revenues and impairing other parties' contractual obligations); *E & E Hauling, Inc. v. Forest Preserve District of DuPage County*, 613 F.2d 675 (7th Cir. 1980). It is likewise well established that a party dealing with the federal government is similarly protected through the Fifth Amendment. In *Lynch v. United States*, 292 U.S. 571 (1934), Justice Brandeis, writing for the Court, examined the constitutional legitimacy of a Congressional attempt to repudiate, in the interest of easing the difficulties of dealing with the depression economy, all insurance policies issued under the War Risk Insurance Act during the World War I era. After concluding that the policies were contracts of the United States, the Court observed:

> The Fifth Amendment commands that property be not taken without making just compensation. Valid contracts are property, whether the obligor be a private individual, a municipality, a State or the

> United States. Rights against the United States arising out of a contract with it are protected by the Fifth Amendment (citations omitted). When the United States enters into contractual relations, its rights and duties therein are governed generally by the law applicable to contracts between private individuals.

Id. at 579. Just as the Government is prohibited by the uncompensated taking clause of the Fifth Amendment from invoking its sovereign authority to rescind its own contractual obligations, it similarly is barred by the due process clause from utilizing that same sovereignty to demand, after the fact, a greater degree of performance from private parties contracting with it. *Cf. Bolling v. Sharpe*, 347 U.S. 497 (1954) (while Fifth Amendment contains no explicit equal protection clause, federal government action in maintaining racially segregated school system held so unjustifiable as to be violative of the due process clause).

The recent case of *Larionoff v. United States*, 533 F.2d 1167, 1179-80 (D.C. Cir. 1976), *aff'd*, 431 U.S. 864 (1977) is illustrative. There, enlisted navy personnel contended that they were entitled to a "variable reenlistment bonus" equal to four times the "regular" reenlistment bonus due to their participation in certain specified programs. The programs were thereafter removed from the list of those eligible for the special bonus, an action which the Government claimed was taken pursuant to a subsequent change in the controlling statute. In holding the plaintiffs entitled to the bonus, the Court of Appeals emphasized:

> Since contractual rights against the Government are property interests protected by the Fifth Amendment, Congressional power to abrogate existing governmental contracts is narrowly circumscribed. And although Congress may constitutionally impair existing contract rights in the exercise of a paramount governmental power such as the "War Powers," Congress is "without power *to reduce expenditures* by abrogating contractual obligations of the United States."

Id. (citations omitted). In affirming, the Supreme Court concluded, as I believe this court should today, that the Congressional enactment in question should not be read to permit the United States to ignore the terms of the original contract. As the Court observed, "if Congress had such an intent, serious constitutional questions would be presented." 431 U.S. at 879.

Turning finally to the regulations in issue, while I am reluctant to prejudge the merits of this litigation, it seems patent to me that certain of the regulations are not within the scope of the Secretary's authority by virtue of the fact that they impose obligations on the facilities far in excess of those agreed to at the time of contracting. With respect to the uncompensated care regulations, those provisions found at 42 C.F.R. §§ 124.503(b), and 124.509(b), are, in my view, invalid.[19] I think that the Secretary may permissibly define, as in § 124.503(a), certain levels of indigent care which will presumptively constitute compliance with the uncompen-

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[19] Section 124.503(b) provides as follows:

> (b) Deficit in compliance—(1) Facilities assisted under Title VI—If in any fiscal year a facility assisted under Title VI of the Act fails to meet its annual compliance level, it shall provide uncompensated services in an amount sufficient to make up that deficit (as adjusted under paragraph (d)). The facility may make up a deficit at any time during its period of obligation or in the year or years (if necessary) immediately following, except where the facility failed to provide uncompensated services at the required level although financially able to do so, or where the facility did not comply with the requirements of this subpart.

Id. Section 124.509(b) provides:

> A facility may not include the following in computing the uncompensated services it provides:
>
> (b) Any amount in excess of the payment that the facility has received, or is entitled to receive, from a third party insurer or under a governmental program where the facility has agreed or is otherwise required to accept this payment as payment in full for the services.
>
> . . .

Id.

sated care assurance. The infirmity in § 124.503(b), however, is that the carrying over of "deficits" in compliance levels goes well beyond defining compliance. Rather, the provision is a penalty and is therefore inconsistent with the statutory exception for financial infeasibility. The regulation is not limited to facilities that were able to meet the uncompensated care obligation without fiscal hardship, but rather applies to all facilities, including those that were legitimately within the express terms of the exception. Further, the fact that the regulation merely provides for a carry-over rather than a fine or other sanction does not cure the infirmity because the effect in the future will be to impose uncompensated care obligations in excess of those specified by § 124.503(a) as reasonable.

With respect to § 124.509(b), I do not regard it as a fair definition of compliance for the Secretary to refuse to permit hospitals to consider as a part of their volume of uncompensated care, the difference between the normal charge for a service and that reimbursed by third party payors such as Medicare. Such a definition penalizes the hospital for accepting Medicare patients, a fact which is particularly inequitable in light of the fact that the community service regulations require the facility to do so. If Medicare does not pay the full, normal cost of a procedure, the hospital should be permitted to consider the balance as uncompensated care. To hold otherwise will permit the Government to establish what will constitute a reasonable volume of charity care in one regulation, and yet exact by means of a second regulation additional services for which the hospital will be paid, in many instances, less than the full charge.

Regarding the community service regulations, the Secretary has, in my opinion, overstepped her authority in promulgating §§ 124.603(d)(1) and .603(d)(2). These regulations provide:

> (d) *Exclusionary admissions policies.* A facility is out of compliance with its community service assurance if it uses an admission policy that has the effect of excluding persons on a ground other than

those permitted under paragraph (a) of this section. Illustrative applications of this requirement are described in the following paragraphs:

(1) A facility has a policy or practice of admitting only those patients who are referred by physicians with staff privileges at the facility. If this policy or practice has the effect of excluding persons who reside (or for Title XVI facilities, are employed) in the community from the facility because they do not have a private family doctor with staff privileges at the facility, the facility would not be in compliance with its assurance. The facility is not required to abolish its staff physician admissions policy as a usual method for admission. However, to be in compliance with its community service assurance it must make alternative arrangements to assist area residents who would otherwise be unable to gain admission to obtain services available in the facility. Examples of alternative arrangements a facility might use include:

(i) authorizing the individual's physician, if licensed and otherwise qualified, to treat the patient at the facility even though the physician does not have staff privileges at the facility;

(ii) for those patients who have no physician, obtaining the voluntary agreement of physicians with staff privileges at the facility to accept referrals of such patients, perhaps on a rotating basis;

(iii) if an insufficient number of physicians with staff privileges agree to participate in a referral arrangement, requiring acceptance of referrals as a condition to obtaining or renewing staff privileges;

(iv) establishing a hospital-based primary care clinic through which patients needing hospitalization may be admitted; or

(v) hiring or contracting with qualified physicians to treat patients who do not have private physicians.

(2) A facility, as required, is a qualified provider under the Title XIX medicaid program, but few or none of the physicians with staff privileges at the facility or in a particular department or subdepartment of the facility will treat medicaid patients. If the effect is that some medicaid patients are excluded from the facility or from any service provided in the facility, the facility is not in compliance with its community service assurance. To be in compliance a facility does not have to require all of its staff physicians to accept medicaid. However, it must take steps to ensure that medicaid beneficiaries have full access to all of its available services. Examples of steps that may be taken include:

(i) obtaining the voluntary agreement of a reasonable number of physicians with staff privileges at the facility and in each department or subdepartment to accept referral of medicaid patients, perhaps on a rotating basis;

(ii) if an insufficient number of physicians with staff privileges agree to participate in a referral arrangement, requiring acceptance of referrals as a condition to obtaining or renewing staff privileges;

(iii) establishing a clinic through which medicaid beneficiaries needing hospitalization may be admitted; or

(iv) hiring or contracting with physicians to treat medicaid patients.

Both these provisions go far beyond the original promise by the hospitals to allow access to the facility by all members of the community, and instead have placed affirmative obligations on facilities either to alter their policies regarding the admission of physicians to their staffs or shoulder the burden of locating private doctors to treat those who have no physician with staff privileges, or to open clinics to serve such a purpose. While the Government ingenuously characterizes the above described methods as "examples" of ways in which compliance might be achieved, a careful reading

indicates that adherence to the "examples" would be the only method of achieving "compliance."

With respect to the remaining regulations, although fuller factual development in the district court might demonstrate additional infirmities, I am not prepared to say at this juncture that the district court abused its discretion in refusing preliminary relief. As to those that I have described above, however, even bearing in mind the deference we are bound to give the Secretary's interpretation, *see Udall v. Tallman*, 380 U.S. 1, 4 (1965), I think that appellant has more than met its burden of showing a likelihood of success.

II.

With respect to the remaining requirements for preliminary relief, I likewise think that the AHA has shown its entitlement to preliminary relief. The substantial alterations in hospital procedures which will be required in order to comply with the community service regulations involve not merely pecuniary damages, but additionally pose dangers that some facilities will be forced to lower their standards for staff admission or will be required to find some means of persuading already overburdened physicians to accept additional patients to avoid a finding that the facility is not in compliance. While I am not advocating that persons in need of treatment be turned away, I think that particularly with respect to those who are able to pay for care, a hospital may reasonably require such persons to make their own arrangements for a doctor. I do not, however, challenge the regulation requiring hospitals to treat all emergency cases. *See* 42 C.F.R. § 124.603(b).

Regarding the uncompensated care regulations, I think that while the harm which may be suffered by the AHA facilities is essentially pecuniary, it nevertheless will be irreparable in the sense that facilities will never be able to recover for the excess services provided in efforts to comply with the cost of the regulations. Particularly in an era when hospitals are in increasing financial difficulties due to the fact that many are

operating with high percentages of empty beds, such a burden should not be imposed.

Finally, regarding the "public interest" and "balancing" requirements, this litigation does not involve an assertion by AHA that its members should be permitted to deny care they are obligated to furnish under the terms of their assurances. Rather, it involves the question of whether HEW, which until recently failed to enforce any of the statutory obligations, has now, to make up for lost time, indulged in administrative overkill. Because this appears to me to be true with regard to the above mentioned regulations, I would reverse in part, as set forth herein, the district court's denial of preliminary relief.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

Subpart F—Reasonable Volume of Uncompensated Services to Persons Unable To Pay

AUTHORITY: Sec. 215, 1825, 1803(6), Public Health Service Act as amended: 58 Stat. 690, 88 Stat. 2249, 2259; (42 U.S.C. 216, 300m-4, 300o-1(6)).

SOURCE: 44 FR 29375, May 18, 1979, unless otherwise noted.

§ 124.501 Applicability.

(a) The provisions of this subpart apply to any recipient of Federal assistance under Title VI or XVI of the Public Health Service Act that gave an assurance that it would make available, in the facility or portion of the facility constructed, modernized or converted with that assistance, a reasonable volume of services to persons unable to pay for the services.

(b) The provisions of this subpart apply to facilities for the following periods:

(1) *Facilities assisted under Title VI.* Except where the deficit and excess compliance provisions provide for a longer or shorter period, a facility assisted under Title VI of the Act shall provide uncompensated services at the annual compliance level required by § 124.503(a) for:

(i) Twenty years after the completion of construction, in the case of a facility for which the Secretary provided grant assistance under section 606 of the Act; or

(ii) The period from completion of construction until the amount of a direct loan under sections 610 or 623 of the Act, or the amount of a loan with respect to which the Secretary provided a guarantee and interest subsidy under section 623 of the Act, is repaid, in the case of a facility for which such a loan was made.

(iii) "Completion of construction" means:

(A) The date on which the Secretary determines the facility was opened for service;

(B) If the opening date is not available, it means the date on which the Secretary approved the final part of the facility's application for assistance under Title VI of the Act;

(C) If the date of final approval is not available, it means whatever date the Secretary determines most reasonably approximates the date of final approval.

(2) *Facilities assisted under Title XVI.* The provisions of this subpart apply to a facility assisted under Title XVI of the Act at all times following the Secretary's approval of the facility's application for assistance under Title XVI, except that if the facility does not at the time of that approval provide health services, the assurance applies at all times following the facility's initial provision of health services to patients, as determined by the Secretary.

§ 124.502 Definitions.

As used in this subpart—

"Act" means the Public Health Service Act, as amended.

"Allowable credit" for services provided to a specific patient means the lesser of the facility's usual charge for those services, or the usual charge multiplied by the percentage which the total allowable cost as reported by the facility in the facility's preceding fiscal year under Title XVIII of the Social Security Act (42 U.S.C. 1395) and Subpart D of the implementing regulations (42 CFR 405.401 *et seq.*)

bears to the facility's total patient revenues for the year.

"Applicant" means a person who requests uncompensated services or on whose behalf uncompensated services are requested.

"Facility" means an entity that received assistance under Title VI or XVI of the Act and provided an assurance that it would provide a reasonable volume of services to persons unable to pay for the services.

"Federal assistance" means assistance received by the facility under Title VI or Title XVI of the Act and any assistance supplementary to that Title VI or Title XVI assistance received by the facility under any of the following acts: the District of Columbia Medical Facilities Construction Act of 1968, 82 Stat. 631 (Pub. L. 90-457); the Public Works Acceleration Act of 1962 (42 U.S.C. 2641, *et seq.*); the Public Works and Economic Development Act of 1965 (42 U.S.C. 3121, *et seq.*); the Appalachian Regional Development Act of 1965, as amended (40 U.S.C. App.); the Local Public Works Capital Development and Investment Act of 1976 (Pub. L. 94-369). In the case of a loan guarantee with interest subsidy, or a direct loan sold and guaranteed by the Secretary with an interest subsidy, the amount of Federal assistance under Title VI or Title XVI for a fiscal year is the total amount of the interest subsidy that the Secretary will have paid by the close of that fiscal year, as well as any other payments which the Secretary has made as of the beginning of the fiscal year on behalf of the facility in connection with the loan guarantee or the direct loan which has been sold.

"Fiscal year" means the facility's fiscal year.

"Health Systems Agency" or "HSA" means an agency fully or conditionally designated by the Secretary under section 1515 of the Act.

"Operating costs" for any fiscal year means the total operating expenses of a facility as set forth in an audited financial statement, minus the amount of reimbursement, if any, received (or if not received, claimed) in that year under Titles XVIII and XIX of the Social Security Act.

"Persons unable to pay" means persons who meet the income criteria set out in § 124.506 of this subpart.

"Request for uncompensated services" means any indication by or on behalf of an individual seeking services of the facility of the individual's inability to pay for services. A request for uncompensated services may be made at any time, including following institution of a collection action against the individual.

"Secretary" means the Secretary of Health and Human Services or his delegates.

"State agency" means the agency of a State fully or conditionally designated by the Secretary as the State health planning and development agency under section 1521 of the Act.

"Uncompensated services" means services that are made available to persons unable to pay for them without charge or at a charge which is less than the allowable credit for those services. The amount of uncompensated services provided in a fiscal year is the total allowable credit for services less the amount charged for the services following an eligibility determination. In determining the amount of uncompensated services, the Secretary includes only those services provided to individuals with respect to whom the facility has made a written determination of eligibility.

§ 124.503 Compliance level.

(a) *Annual compliance level.* (1) A facility is in compliance with its assurance to provide a reasonable volume of services to persons unable to pay if it provides for the fiscal year uncompensated services at a level not less than the lesser of—

(i) Three percent of its operating costs for the most recent fiscal year for which an audited financial statement is available; or

(ii) Ten percent of all Federal assistance provided to or on behalf of the facility, adjusted by a percentage equal to the percentage change in the national Consumer Price Index for medical care between the year in which the facility received assistance or 1979, whichever is later, and the most recent year for which a pub-

lished Index is available. For purposes of this paragraph, the Federal assistance in the case of a loan which is guaranteed or made and sold by the Secretary will be deemed to have been provided in the year in which the Secretary made the loan.

(b) *Deficit in compliance*— (1) *Facilities assisted under Title VI*—If in any fiscal year a facility assisted under Title VI of the Act fails to meet its annual compliance level, it shall provide uncompensated services in an amount sufficient to make up that deficit (as adjusted under paragraph (d)). The facility may make up a deficit at any time during its period of obligation or in the year or years (if necessary) immediately following, except where the facility failed to provide uncompensated services at the required level although financially able to do so, or where the facility did not comply with the requirements of this subpart.

(2) *Facilities assisted under Title XVI.* If in any fiscal year a facility assisted under Title XVI of the Act fails to meet its annual compliance level but has otherwise complied with the requirements of this subpart, the amount of uncompensated services provided in that year constitutes compliance with this subpart.

(c) *Excess compliance.* (1) Whenever a facility provides in a fiscal year uncompensated services in an amount exceeding its annual compliance level, it may apply the amount of excess (as adjusted under paragraph (d)) to reduce its annual compliance level in any subsequent fiscal year. The facility may use any excess amount to reduce its annual compliance level only if the services in excess of the annual compliance level are provided in accordance with the requirements of this subpart.

(2) A facility assisted under Title VI may in any fiscal year apply the amount of excess credited under this paragraph to satisfy the remainder of its obligation to provide uncompensated services. In any fiscal year, the amount of uncompensated services required to satisfy the remainder of the facility's obligation is its annual compliance level for that fiscal year provided multiplied by the number of years remaining in its period of obligation, plus any deficits required to be made up under this section.

(d) *Calculation and adjustment of deficit and excess.* (1) The amount of a deficit or excess in uncompensated services in any fiscal year is the difference between the facility's annual compliance level for that year and the amount of uncompensated services the facility provided in that year.

(2) The amount of any deficit the facility makes up, and the amount of any excess compliance applied to reduce a facility's annual compliance level, must be adjusted by a percentage equal to the percentage change in the National Consumer Price Index for medical care between the fiscal year in which the facility had a deficit or provided the excess, and the fiscal year in which the facility makes up the deficit or applies the excess to reduce its annual compliance level or satisfy its remaining obligations.

§ 124.504 Affirmative action requirement.

(a) A facility that fails to meet its annual compliance level in any fiscal year shall adopt and implement an affirmative action plan, except where it claims and reports to the Secretary that it was financially unable to provide uncompensated services at the annual compliance level.

(b) The affirmative action plan must include provisions that reasonably can be expected to enable the facility to meet its annual compliance level. An affirmative action plan may include, among other approaches devised by the facility:

(1) Wide notice of the availability of uncompensated services at the facility. Notice under this paragraph may include:

(i) Publication of notices in newspapers of general circulation in the area;

(ii) Announcement of the availability of uncompensated services in other communication media in the area (such as radio and television stations); and

(iii) Notification of the availability of uncompensated services to organizations in the area that would be likely to refer persons in need of uncompensated services to the facility (such as

legal services organizations, community action agencies, and other public and private social services agencies).

(2) If the facility's allocation plan restricts the types of services that will be provided as uncompensated services, or restricts uncompensated services to persons in Category A, expansion of the allocation plan to include other types of services or persons in Category B.

(3) Expansion of the area served by the facility for the purpose of providing uncompensated services; and

(4) Establishment of arrangements with other providers of health care under which those providers (if willing and able to do so) will refer to the facility persons requesting uncompensated services.

(c) The facility shall implement its affirmative action plan when it submits it to the Secretary under § 124.510(a), and shall provide uncompensated services in accordance with the plan, incorporating any changes the Secretary may require, until the annual compliance level is reached in a fiscal year.

§ 124.505 Notice of availability of uncompensated services.

(a) *Published notice.* A facility shall, no later than 60 days before the beginning of its fiscal year, publish in a newspaper of general circulation in its area notice of its uncompensated services obligation. The notice shall include, at a minimum:

(1) The plan of allocation the facility proposes to adopt;

(2) The amount of uncompensated services the facility intends to make available in the fiscal year or a statement that the facility will provide uncompensated services to all persons unable to pay who request uncompensated services; and

(3) An explanation if the amount of uncompensated services the facility intends to make available in a fiscal year is less than the annual compliance level, either because it is not financially able to meet this level or because it has credited excess compliance from another fiscal year. If a facility has satisfied its remaining uncompensated services obligation since the last published notice under this paragraph, or will satisfy the remaining obligation during the fiscal year, the explanation must include this information.

(b) *Notice to HSA.* (1) The facility shall simultaneously provide a copy of the notice under paragraph (a) to the HSA for the area. The HSA may seek public comment, comment to the facility on the extent to which the allocation plan will or will not meet community needs, or take any other appropriate action.

(2) The facility may revise the plan published under paragraph (a) based on comments received from the HSA or the public. The facility shall send a copy of the plan as adopted to the HSA at the beginning of the fiscal year.

(3) A facility may change its allocation plan during a fiscal year after providing notice to the HSA of the revised plan.

(c) *Posted notice.* (1)(i) The facility shall post notices, which the Secretary supplies in English and Spanish, in appropriate areas in the facility, including but not limited to the admissions area, the business office and the emergency room.

(ii) If in the service area of the facility the "usual language of households" of ten percent or more of the population, according to the most recent figures published by the Bureau of the Census, is other than English or Spanish, the facility shall translate the notice into that language and post the translated notice on signs substantially similar in size and legibility to, and posted with, those supplied under paragraph (c)(1)(i) of this section.

(iii) The facility shall make reasonable efforts to communicate the contents of the posted notice to persons who it has reason to believe cannot read the notice.

(2) If a facility determines that it has provided uncompensated services in an amount sufficient to meet its annual compliance level for the fiscal year or its allocation for any period specified in its allocation plan, and that it will not continue to provide uncompensated services during the fiscal year of the appropriate period, it may post an additional notice stating that it has satisfied its obligation for the fiscal year or appropriate period, and

when additional uncompensated services will be available.

(d) *Individual notice.* (1) In any period during a fiscal year in which uncompensated services are available in the facility, the facility shall provide individual written notice of the availability of uncompensated services to each person who seeks services in the facility on behalf of himself or another. The individual written notice must:

(i) State that the facility is required by law to provide a reasonable amount of care without or below charge to people who cannot afford care;

(ii) Set forth the criteria the facility uses for determining eligibility for uncompensated services (in accordance with the financial eligibility criteria and the allocation plan);

(iii) State the location in the facility where anyone seeking uncompensated services may request them; and

(iv) State that the facility will make a written determination of whether the person will receive uncompensated services, within two working days of a request for uncompensated services.

(2) The facility shall provide the individual written notice before providing services, except where the emergency nature of the services provided makes prior notice impractical. If this exception applies, the facility shall provide the written notice to next of kin or to the patient as soon as practical, but not later than when first presenting a bill for services.

(3) The facility shall make reasonable efforts to communicate the contents of the individual written notice to persons who it has reason to believe cannot read the notice.

§ 124.504 Financial eligibility criteria for identifying persons unable to pay.

(a) A person unable to pay for health services is a person who falls into either of the following categories:

(1) *Category A*—A person whose individual or family income, as applicable, for the 12 months preceding the determination of eligibility is not more than the current poverty income guideline of the Community Services Administration (as set forth in 45 CFR 1060.2-1 *et seq.*) that applies to the individual or family. The facility shall provide uncompensated services to persons in this category without charge.

(2) *Category B*—A person whose individual or family income, as applicable, for the 12 months preceding the determination of eligibility is greater than the current poverty income guideline of the Community Services Administration (as set forth in 45 CFR 1060.2-1 *et seq.*) that applies to the individual or family but not more than twice that guideline. If persons in Category B are included in the allocation plan, the facility shall provide uncompensated services to these persons without charge, or in accordance with a schedule of charges, as specified in the allocation plan.

(b) A person is eligible for uncompensated services if his annual income is at or below the level established under paragraph (a) when calculated by either of the following methods:

(1) Multiplying by four the person's income for the three months preceding the determination of eligibility; or

(2) Using the person's actual income for the 12 months preceding the determination of eligibility.

§ 124.507 Allocation of services: plan requirement.

(a) A facility shall provide its uncompensated services in accordance with a plan that sets out a method by which the facility will distribute its uncompensated services among persons unable to pay. In developing its plan the facility shall take into consideration comments it receives from the HSA or others with respect to community need. The plan must:

(1) Include the type of services that will be made available;

(2) Specify the method, if any, for distibuting those services in different periods of the year;

(3) State whether persons eligible under Category B criteria will be provided uncompensated services, and if so, whether the services will be available without charge or at a reduced charge;

(4) If services will be made available to Category B persons at a reduced charge, specify the method used for reducing charges, and provide that

this method is applicable to all persons in Category B; and

(5) Provide that the facility provides uncompensated services to all persons eligible under the plan who request uncompensated services.

(b) A facility may adopt any allocation plan that meets the requirements of paragraph (a). If the facility fails to adopt and publish a plan as required by § 124.505 it will be presumed to have adopted a plan under which it provides all services of the facility without charge to all persons unable to pay who first request such services, until its annual compliance level has been met for the fiscal year.

§ 124.506 Determinations of eligibility.

(a) *Determinations.* In any period or periods in a fiscal year in which uncompensated services are available, the facility shall make a determination of eligibility for uncompensated services within two working days following the request for uncompensated services. The facility shall give the applicant a copy of the determination promptly.

(b) *Content of favorable determinations.* A determination that an applicant is eligible must indicate:

(1) That the facility will provide uncompensated services at no charge or at a specified charge less than the allowable credit for the services;

(2) The date on which services were requested;

(3) The date on which the determination was made;

(4) The income of the applicant; and

(5) The date on which services were or will be first provided to the applicant.

(c) *Reasons for denial.* The facility shall provide each applicant who requests uncompensated services and is denied them, in whole or in part, a written and dated statement of the reasons for the denial when the denial is made. This requirement applies throughout the facility's fiscal year.

(d) *Verification.* A facility may, as a condition to providing uncompensated services to any applicant, require the applicant to furnish any information that is reasonably necessary to substantiate the applicant's income.

§ 124.509 Exclusions from uncompensated services.

A facility may not include the following in computing the uncompensated services it provides:

(a) Any amount that the facility has received, or is entitled to receive, from a third party insurer or under a governmental program, except where the person to whom the facility provides services refused to take reasonable actions necessary to obtain the entitlement.

(b) Any amount in excess of the payment that the facility has received, or is entitled to receive, from a third party insurer or under a governmental program where the facility has agreed or is otherwise required to accept this payment as payment in full for the services;

(c) Any amount for services provided 96 hours or more following notification to the facility by a professional standards review organization (PSRO) that the PSRO disapproved the services under section 1155(a)(1) of the Social Security Act; and

(d) Any amount for which reimbursement would be available under a governmental program (such as medicare or medicaid) in which the facility, although eligible to do so, and required by § 124.603(c)(1) to do so, does not participate.

§ 124.510 Reporting and record maintenance requirements.

(a) *Reporting requirements*—(1) *Timing of reports*—(i) A facility shall submit to the Secretary a report to assist the Secretary in determining compliance with this subpart once every three fiscal years, on a schedule to be prescribed by the Secretary.

(ii) A facility shall submit the required report more frequently than once every three years under the following circumstances:

(A) If the facility determines that in the preceding fiscal year it did not provide uncompensated services at the annual compliance level, it shall submit a report in the fiscal year in which the deficit is determined.

(B) If the Secretary determines, and notifies the facility in writing, that a report is needed for proper adminis-

tration of the program, the facility shall submit a report within 90 days after receiving notice from the Secretary, or within 90 days after the close of the fiscal year, whichever is later.

(iii) Except as specified in paragraph (a)(ii)(B) of this section, the reports required by this section shall be submitted within 90 days after the close of the fiscal year, unless a longer period is approved by the Secretary for good cause.

(2) *Content of report.* The report must include the following information, in a form prescribed by the Secretary:

(i) Information that the Secretary prescribes to permit a determination of whether a facility has met the annual compliance level for the fiscal years covered by the report;

(ii) The date on which the notice required by § 124.508(a) was published and sent to the HSA for the area, and the name of the newspaper that printed the notice;

(iii) If the amount of uncompensated services provided by the applicant in the preceding fiscal year was lower than the annual compliance level, an explanation of why the facility did not meet the required level. If the facility claims that it failed to meet the required compliance level because it was financially unable to do so, it shall explain and document its claim;

(iv) If the facility is required to submit an affirmative action plan, a copy of the plan. If an affirmative action plan was in effect during the preceding fiscal year, documentation of actions taken to implement the plan; and

(v) Other information that the Secretary prescribes.

(3) A facility shall provide a copy of any report to the HSA for the area when submitting it to the Secretary.

(4) *Institution of suit.* Not later than 10 days after being served with a summons or complaint, the facility shall notify the Regional Health Administrator for the Region of HHS in which it is located of any legal action brought against it alleging that it has failed to comply with the requirements of this subpart.[1]

(b) *Record maintenance requirements.* (1) A facility shall maintain, make available for public inspection consistent with personal privacy, and provide to the Secretary on request, any records necessary to document its compliance with the requirements of this subpart in any fiscal year, including:

(i) Any documents from which the information required to be reported under paragraph (a) of this section was obtained;

(ii) Accounts which clearly segregate uncompensated services from other accounts; and

(iii) Copies of the determinations of eligibility under § 124.508(b).

A facility shall maintain these records until 180 days following the close of the Secretary's investigation under § 124.511(a).

(2) In any fiscal year a facility may stop providing individual written notice, and may stop making eligibility determinations, only if it maintains records that document on a current basis that it has met its annual compliance level for the fiscal year or appropriate period specified in its allocation plan.

(3) A facility shall, within 60 days of the end of each fiscal year, ascertain the amount of uncompensated services it provided in that fiscal year. Documents that support the facility's determination shall be made available to the public or the HSA for the area on request. If a report is or will be filed under § 124.510 a facility may respond to a request by providing a copy of the report to the requester.

§ 124.511 Investigation and enforcement.

(a) *Investigations.* (1) The Secretary periodically investigates the compliance of facilities with the requirements of this subpart, and investigates complaints.

(2)(i) A complaint is considered to be filed with the Secretary on the date the following information is received in the Office of the Regional Health

[1] The addresses of the Regional Offices of HHS are set out in 45 CFR 5.31.

Administrator for the Region of HHS in which the facility is located:

(A) The name and address of the person making the complaint or on whose behalf the complaint is made;

(B) The name and location of the facility;

(C) The date or approximate date on which the event complained of occurred; and

(D) A statement of what actions the complainant considers to violate the requirements of this subpart.

(ii) The Secretary promptly provides a copy of the complaint to the facility named in the complaint.

(3) When the Secretary investigates a facility, the facility shall provide to the Secretary on request any documents, records and other information concerning its operations that relate to the requirements of this subpart.

(4) Section 1612(c) of the Act provides that if the Secretary dismisses a complaint or the Attorney General has not brought an action for compliance within six months from the date on which the complaint is filed, the person filing it may bring a private action to effectuate compliance with the assurance. If the Secretary determines that he will be unable to issue a decision on a complaint or otherwise take appropriate action within the six month period, he may, based on priorities for the disposition of complaints that are established to promote the most effective use of enforcement resources, or on the request of the applicant, dismiss the complaint without a finding as to compliance prior to the end of the six month period, but no earlier than 45 days after the complaint is filed.

(b) *Enforcement.* (1) If the Secretary finds, based on his investigation under paragraph (a) of this section, that a facility did not comply with the requirements of this subpart, he may take any action authorized by law to secure compliance, including but not limited to voluntary agreement or a request to the Attorney General to bring an action against the facility for specific performance.

(2) A facility that has denied uncompensated services to any person because it failed to comply with the requirements of this subpart will not be in compliance with its assurance until it takes whatever steps are necessary to remedy fully the noncompliance.

(3)(i) If in a fiscal year a facility fails to provide uncompensated services in an amount sufficient to meet its compliance level, and the Secretary determines—

(A) That, contrary to the report filed under § 124.510, the facility was financially able to provide some or all of the deficit amount in the fiscal year in question; or

(B) That the deficit was due to the facility's failure to comply with a requirement of this subpart—the facility shall provide uncompensated services in an amount sufficient to make up the deficit in the fiscal year following the finding, unless the Secretary determines that it is financially unable to do so. If the Secretary determines that the facility is not financially able to provide all of the deficit in the fiscal year following the finding, the Secretary sets a compliance level for that year and subsequent years that permits the deficit to be made up in as short a period of time as he determines is consistent with the financial stability of the facility. Any deficit is calculated and adjusted in accordance with § 124.503(d).

(ii) Where a facility indicates in its published notice that it will provide uncompensated services in an amount below the annual compliance level because of a financial inability to meet the annual compliance level, and the Secretary determines during the fiscal year that the facility is financially able to provide additional uncompensated services, he may require the facility to provide additional appropriate amounts of uncompensated services during the fiscal year.

(iii) In determining whether a facility was or is financially able to meet its annual compliance level, the Secretary will consider factors such as:

(A) The ratio of revenues to expenses;

(B) The occupancy rate;

(C) The ratio of current assets to current liabilities;

(D) The average cost per patient day;

(E) The number of days of operating expenses in accounts payable;

(F) The number of days of revenues in accounts receivable;

(G) The sinking fund (or depreciation fund) balance;

(H) The debt coverage ratio; and

(I) The availability of restricted or unrestricted funds (such as an endowment) available for charitable use. In making this determination the Secretary will consider any comments submitted by the HSA for the area or by other persons.

(4)(i) Where a facility submits an affirmative action plan, the Secretary reviews the plan. If the Secretary determines that the plan is inadequate, he notifies the facility of additional actions it shall incorporate into the plan, including but not limited to, any of the illustrative approaches listed in § 124.504(b).

(ii) In determining whether an affirmative action plan is acceptable, the Secretary will consider any comments submitted by the HSA for the area or by other persons.

§ 124.512 Agreements with State agencies.

(a) Where the Secretary finds that it will promote the purposes of this subpart, and the State agency is able and willing to do so, he may enter into an agreement with the State agency for the State agency to assist him in administering this subpart in the State. An agreement may be terminated by the Secretary or the State agency on 60 days' notice.

(b) Under an agreement, the State agency will provide the Secretary with any assistance he requests in any one or more of the following areas, as set out in the agreement:

(1) Investigation of complaints regarding noncompliance;

(2) Monitoring of the compliance of facilities with the requirements of this subpart;

(3) Review of affirmative action plans submitted under § 124.504;

(4) Review of reports submitted under § 124.510;

(5) Making initial decisions for the Secretary with respect to compliance, subject to appeal by any party to the Secretary or review by the Secretary on his own initiative; and

(6) Application of any sanctions available to it under State law (such as license revocation or termination of State assistance) against facilities determined to be out of compliance with the requirements of this subpart.

(c) A State agency may use funds received under section 1525 of the Act to pay for expenses incurred in the course of carrying out this agreement.

(d) Nothing in this subpart precludes any State from taking any action authorized by State law regarding the provision of uncompensated services by facilities in the State as long as the action taken does not prevent the Secretary from enforcing the requirements of this subpart.

Subpart G—Community Service

AUTHORITY: Sec. 215, 1525, 1602(6), Public Health Service Act as amended; 58 Stat 690, 88 Stat. 2249, 2259; 42 U.S.C. 216, 300m-4, 300o-1(6).

SOURCE: 44 FR 29379, May 18, 1979, unless otherwise noted.

§ 124.601 Applicability.

The provisions of this subpart apply to any recipient of Federal assistance under Title VI or XVI of the Public Health Service Act that has given an assurance that it would make the facility or portion thereof assisted available to all persons residing (and, in the case of Title XVI assisted applicants, employed), in the territorial area it serves. This assurance is referred to in this subpart as the "community service assurance."

§ 124.602 Definitions.

As used in this subpart:

"Act" means the Public Health Service Act, as amended.

"Facility" means the an entity that received assistance under Title VI or Title XVI of the Act and provided a community service assurance.

"Fiscal year" means facility's fiscal year.

"Secretary" means the Secretary of Health and Human Services or his delegatee.

"Service area" means the geographic area designated as the area served by the facility in the most recent State plan approved by the Secretary under Title VI, except that, at the request of

the facility, the Secretary may designate a different area proposed by the facility when he determines that a different area is appropriate based on the criteria in 42 CFR 53.1(d).

"State agency" means the agency of a state fully or conditionally designated by the Secretary as the State health planning and development agency of the State under section 1521 of the Act.

§ 124.603 Provision of services.

(a) *General.* (1) In order to comply with its community service assurance, a facility shall make the services provided in the facility or portion thereof constructed, modernized, or converted with Federal assistance under Title VI or XVI of the Act available to all persons residing (and, in the case of facilities assisted under Title XVI of the Act, employed) in the facility's service area without discrimination on the ground of race, color, national origin, creed, or any other ground unrelated to an individual's need for the service or the availability of the needed service in the facility. Subject to paragraph (b) (concerning emergency services) a facility may deny services to persons who are unable to pay for them unless those persons are required to be provided uncompensated services under the provisions of Subpart F.

(2) A person is residing in the facility's service area for purposes of this section if the person:

(i) Is living in the service area with the intention to remain there permanently or for an indefinite period;

(ii) Is living in the service area for purposes of employment; or

(iii) Is living with a family member who resides in the service area.

(b) *Emergency services.* (1) A facility may not deny emergency services to any person who resides (or, in the case of facilities assisted under Title XVI of the Act, is employed) in the facility's service area on the ground that the person is unable to pay for these services.

(2) A facility may discharge a person that has received emergency services, or may transfer the person to another facility able to provide necessary services, when the appropriate medical personnel determine that discharge or transfer will not subject the person to a substantial risk of deterioration in medical condition.

(c) *Third party payor programs.* (1) The facility shall make arrangements, if eligible to do so, for reimbursement for services with:

(i) Those principal State and local governmental third-party payors that provide reimbursement for services that is not less than the actual costs, as determined in accordance with accepted cost accounting principles; and

(ii) Federal governmental third-party programs, such as medicare and medicaid.

(2) The facility shall take any necessary steps to insure that admission to and services of the facility are available to beneficiaries of the governmental programs specified in paragraph (c)(1) of this section without discrimination or preference because they are beneficiaries of those programs.

(d) *Exclusionary admissions policies.* A facility is out of compliance with its community service assurance if it uses an admission policy that has the effect of excluding persons on a ground other than those permitted under paragraph (a) of this section. Illustrative applications of this requirement are described in the following paragraphs:

(1) A facility has a policy or practice of admitting only those patients who are referred by physicians with staff privileges at the facility. If this policy or practice has the effect of excluding persons who reside (or for Title XVI facilities, are employed) in the community from the facility because they do not have a private family doctor with staff privileges at the facility, the facility would not be in compliance with its assurance. The facility is not required to abolish its staff physician admissions policy as a usual method for admission. However, to be in compliance with its community service assurance it must make alternative arrangements to assist area residents who would otherwise be unable to gain admission to obtain services available in the facility. Examples of alternative arrangements a facility might use include:

(i) Authorizing the individual's physician, if licensed and otherwise qualified, to treat the patient at the facility even though the physician does not have staff privileges at the facility;

(ii) For those patients who have no physician, obtaining the voluntary agreement of physicians with staff privileges at the facility to accept referrals of such patients, perhaps on a rotating basis;

(iii) If an insufficient number of physicians with staff privileges agree to participate in a referral arrangement, requiring acceptance of referrals as a condition to obtaining or renewing staff privileges;

(iv) Establishing a hospital-based primary care clinic through which patients needing hospitalization may be admitted; or

(v) Hiring or contracting with qualified physicians to treat patients who do not have private physicians.

(2) A facility, as required, is a qualified provider under the Title XIX medicaid program, but few or none of the physicians with staff privileges at the facility or in a particular department or sub-department of the facility will treat medicaid patients. If the effect is that some medicaid patients are excluded from the facility or from any service provided in the facility, the facility is not in compliance with its community service assurance. To be in compliance a facility does not have to require all of its staff physicians to accept medicaid. However, it must take steps to ensure that medicaid beneficiaries have full access to all of its available services. Examples of steps that may be taken include:

(i) Obtaining the voluntary agreement of a reasonable number of physicians with staff privileges at the facility and in each department or sub-department to accept referral of medicaid patients, perhaps on a rotating basis;

(ii) If an insufficient number of physicians with staff privileges agree to participate in a referral arrangement, requiring acceptance of referrals as a condition to obtaining or renewing staff privileges;

(iii) Establishing a clinic through which medicaid beneficiaries needing hospitalization may be admitted; or

(iv) Hiring or contracting with physicians to treat medicaid patients.

(3) A facility requires advance deposits (pre-admission or pre-service deposits) before admitting or serving patients. If the effect of this practice is that some persons are denied admission or service or face substantial delays in gaining admission or service solely because they do not have the necessary cash on hand, this would constitute a violation of the community service assurance. While the facility is not required to forego the use of a deposit policy in all situations, it is required to make alternative arrangements to ensure that persons who probably can pay for the services are not denied them simply because they do not have the available cash at the time services are requested. For example, many employed persons and persons with other collateral do not have savings, but can pay hospital bills on an installment basis, or can pay a small deposit. Such persons may not be excluded from admission or denied services because of their inability to pay a deposit.

§ 124.604 Posted notice.

(a) The facility shall post notices, which the Secretary supplies in English and Spanish, in appropriate areas of the facility, including but not limited to the admissions area, the business office and the emergency room.

(b) If in the service area of the facility the "usual language of households" of ten percent or more of the population, according to the most recent figures published by the Bureau of the Census, is other than English or Spanish, the facility shall translate the notice into that language and post the translated notice on signs substantially similar in size and legibility to, and posted with, those supplied under paragraph (a).

(c) The facility shall make reasonable efforts to communicate the contents of the posted notice to persons who it has reason to believe cannot read the notice.

§ 124.605 Reporting and record maintenance requirements.

(a) *Reporting requirements*—(1) *Timing of reports*—(i) A facility shall submit to the Secretary a report to assist the Secretary in determining compliance with this subpart once every three fiscal years, on a schedule to be prescribed by the Secretary. The report required by this section shall be submitted not later than 90 days after the end of the fiscal year, unless a longer period is approved by the Secretary for good cause shown.

(ii) A facility shall also submit the required report whenever the Secretary determines, and so notifies the facility in writing, that a report is needed for proper administration of the program. In this situation the facility shall submit the report specified in this section for the filing of reports, within 90 days after receiving notice from the Secretary, or within 90 days after the close of the fiscal year, whichever is later.

(2) *Content of report.* The report must be submitted on a form prescribed by the Secretary and must include information that the Secretary prescribes to permit a determination of whether a facility has met its obligations under this subpart.

(3) The facility shall provide a copy of any report to the HSA for the area when submitting it to the Secretary.

(4) *Institution of suit.* Not later than 10 days after being served with a summons or complaint, the applicant shall notify the Regional Health Administrator for the Region of HHS in which it is located of any legal action brought against it alleging that it has failed to comply with the requirements of this subpart.[1]

(b) *Record maintenance requirements.* (1) A facility shall maintain, make available for public inspection consistent with personal privacy, and provide to the Secretary on request, any records necessary to document its compliance requirements of this subpart in any fiscal year, including documents from which information required to be reported under paragraph (a) of this section was obtained. A facility shall maintain these records until 180 days following the close of the Secretary's investigation under § 124.606(a).

§ 124.606 Investigation and enforcement.

(a) *Investigations.* (1) The Secretary periodically investigates the compliance of facilities with the requirements of this subpart, and investigates complaints.

(2)(i) A complaint is filed with the Secretary on the date on which the following information is received in the Office of the Regional Health Administrator for the Region of HHS in which the facility is located:

(A) The name and address of the person making the complaint or on whose behalf the complaint is made;

(B) The name and location of the facility;

(C) The date or approximate date on which the event complained of occurred, and

(D) A statement of what actions the complainant considers to violate the requirements of this subpart.

(ii) The Secretary promptly provides a copy of the complaint to each facility named in the complaint.

(3) When the Secretary investigates a facility, the facility shall provide to the Secretary on request any documents, records and other information concerning its operations that relate to the requirements of this subpart.

(4) The Act provides that if the Secretary dismisses a complaint or the Attorney General has not brought an action for compliance within six months from the date on which the complaint is filed, the person filing it may bring a private action to effectuate compliance with the assurance. If the Secretary determines that he will be unable to issue a decision on a complaint or otherwise take appropriate action within the six month period, he may, based on priorities for the disposition of complaints that are established to promote the most effective use of enforcement resources, or on the request of the complainant, dismiss the complaint without a finding as to compliance prior to the end of the six month period, but no earlier

[1] The addresses of the Regional Office of HHS are set out in 45 CFR 5.31.

than 45 days after the complaint is filed.

(b) *Enforcement.* (1) If the Secretary finds, based on his investigation under paragraph (a) of this section, that a facility did not comply with the requirements of this subpart, he may take any action authorized by law to secure compliance, including but not limited to voluntary agreement or a request to the Attorney General to bring an action against the facility for specific performance.

(2) If the Secretary finds, based on his investigation under paragraph (a) of this section, that a facility has limited the availability of its services in a manner proscribed by this subpart, he may, in addition to any other action that he is authorized to take in accordance with the Act, require the facility to establish an effective affirmative action plan that in his judgment is designed to insure that its services are made available in accordance with the requirements of this subpart.

§ 124.607 Agreements with State agencies.

(a) Where the Secretary finds that it will promote the purposes of this subpart, and the State agency is able and willing to do so, he may enter into an agreement with the State agency for the State agency to assist him in administering this subpart in the State.

(b) Under an agreement, the State agency will provide the Secretary with any assistance he requests in any one or more of the following areas, as set out in the agreement:

(1) Investigation of complaints of noncompliance;

(2) Monitoring the compliance of facilities with the requirements of this subpart;

(3) Review of affirmative action plans submitted under § 124.606(b);

(4) Review of reports submitted under § 124.608;

(5) Making initial decisions for the Secretary with respect to compliance, subject to appeal by any party to the Secretary or review by the Secretary on his own initiative; and

(6) Application of any sanctions available to it under State law (such as license revocation or termination of State assistance) against facilities determined to be out of compliance with the requirements of this subpart.

(c) A State agency may use funds received under section 1525 of the Act to pay for expenses incurred in the course of carrying out this agreement.

(d) Nothing in this subpart precludes any State from taking any action authorized by State law regarding the provision of services by any facility in the State as long as the action taken does not prevent the Secretary from enforcing the requirements of this subpart.

APPENDIX—INTERIM PROCEDURES AND CRITERIA FOR REVIEW BY HEALTH SYSTEMS AGENCIES OF APPLICATIONS UNDER SECTION 1625 OF THE PUBLIC HEALTH SERVICE ACT

In performing reviews under section 1513 (e) of the Public Health Service Act (42 U.S.C. 3001-2(c)) of applications for grants under section 1625 of the Act, health systems agencies shall use the procedures and criteria stated below. A health systems agency may not conduct such reviews until the procedures and criteria to be used in conducting the reviews have been adopted by the agency and published in newspapers of general circulation within the health service area or other public information channels.

PROCEDURES

The procedures adopted and utilized by a health systems agency for conducting reviews of applications for grants under section 1625 of the Act shall include at least the following: 1. Except as provided below, notification of the beginning of a review within seven days of the receipt by the health systems agency of the application. Where the application was received by the health systems agency prior to publication of this subpart in the FEDERAL REGISTER, notification must be made within seven days of the date on which the health systems agency adopts its procedures and criteria. The notification shall include the proposed schedule for the review, the period within which a public hearing during the course of the review may be requested (which must be a reasonable period from the transmittal of the written notification required above), and the manner in which notification will be provided of the time and place of any hearings so requested. Written notification to members of the public may be provided through newspapers of general circulation in the area and public information channels. Notification to the applicant whose application is being reviewed and all other ap-

plicants for assistance under section 1623 of the Act providing health service in the health service area shall be by mail (which may be as part of a newsletter). The health systems agency must simultaneously notify the Federal funding agency of the beginning of the review.

2. Schedules for reviews which provide that such reviews shall not exceed 60 days from the date of notification made in accordance with paragraph 1 of this section to the date of the written findings made in accordance with paragraph 4 of this section. This does not preclude a health systems agency from conducting its review in less than 60 days.

3. Provision for applicants to submit to the health systems agency (in such form and manner as the agency shall require) such information as the agency deems necessary in order to conduct its review.

4. Written findings which state the basis for the approval or disapproval of the application by the health systems agency. Such findings shall be sent to the applicant, the State health planning and development agency (or agencies), and the Secretary, and shall be available to other upon request.

5. Access by the general public to all such applications reviewed by the health systems agency and to all other written materials pertinent to the agency review.

6. Public hearings in the course of agency review, if requested by one or more persons directly affected by the review. For purposes of this paragraph, a "person directly affected by the review" is as defined in 42 CFR 122.306 (a)(7).

CRITERIA

The specific criteria adopted and utilized by a health systems of this agency to conduct reviews of applications for grants under section 1623 of the Act shall include at least the following:

1. The relationship of the health services of the facility to the applicable health systems plan and annual implementation plan.

2. The relationship of the health services of the facility to the long-range development plan (if any) of the applicant.

3. The need that the population served or to be served by the facility has for the health services of such facility.

4. The availability of alternative, less costly, or more effective methods of providing the health services which the facility provides.

5. The relationship of the health services provided by the facility to the existing health care system of the area.

6. The availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of services by the facility and the availability of alternative uses of such resources for the provision of other health services.

7. The special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service area in which the entities are located or in adjacent health service areas. Such entities may include medical and other health professions schools, multidisciplinary clinics, and other speciality centers.

8. The special needs and circumstances of health maintenance organizations for which assistance may be provided under Title XIII.

9. The costs and methods of the proposed construction or modernization, including the costs and methods of energy provision.

10. The probable impact of the project reviewed on the applicant's costs of providing health services.